Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3350 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 23, 2010 5:45 AM **Physician** STONE - MASON WilhelMINA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Battimore MANOR COAR NUVSING BaltiMORE If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 💢 F 213-36-5839 72 GEORGIA Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location show Department of Health and Mental Hyglene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If I Medical Evan intervent to what the medical Evan intervents to make the medical Evan intervents. 1 Nes 2 No Prince Georges Director 10g. Citizen of What Country? 10e. Street and Number AMADOR Drive 20785 SA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 XNo <u>ک</u> 3 ☐ Widowed 4 X Divorced Completed 16b. Kind of Business/Industry
Prince Georges County 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Board of Education Elementary/Secondary (0-12) College (1-4or 5+) TOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Mae Thompson JOHN STONE, ST ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Darry/ Mason 1701 Ellis Lakes Dr. Apt. 38, Marysville, CA 95801 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD Chesapeake Cremitary 10-30-10 4 ☐ Donation 22. Name and Address of Facility STRICKLAND Funeral Services 21. Signature of Funeral Service License 6500 Allentown Rd, Camp Springs, MD 20748 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final vsician disease or condition resulting in death) Medical xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit so the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical the attending pl JE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Day in the past 12 months? 1 □ Yes 2 ☑ No Month Year 5 ☐ Other (specify) P.0. After this certificate has been signed funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 **N**o 1 ☐ Yes 25. Was case referred to medical Medical Certification: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d Describe how injury occurred 5 ☐ Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number odober 25,2010 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)
To HIRPAPA WA 7505 OSIEY it . Arire suite 509 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER D 2010 12:38M Frederick Eugene Stavinoha Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death TOWSON BALTIMORE SAINT JOSEPH MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. Social Security Number Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) Texas 1 X M 2 □ F Months Days Hours Oct. 6, 1920 454-18-4675 90 Director Usual Residence of Decedent show 10b. County "natural", or items 23a or 28a-f sho dical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Baltimore 1 Yes 2 No Maryland Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1 Southerly Ct. Unit 507 21286 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give 10/11 Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 res, Give Year or Dates.1940–46 1 ☐ Yes 2 🕅 No Specify: Specify: White 3 Divorced 4 Divorced event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 9 years Railroad Trainman B & O Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ of Health and Menta item 27 is marked other traumatic e Edwin Lucas Stavinoha Annie Marie Zabransky 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important; If item 27 is any injury or other tra Helen M. Stavinoha (wife) Unit 507 Southerly Ct. Towson, Maryland 21286 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10-26-10 Baltimore, Maryland Green Mount Crematory Signature of Funeral Service Licensee 22, Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Pelice 6500 York Road Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final CONGESTIVE HEART FAILURE 3 MONTH'S Physician, Medical resulting in death) Due to (or as a consequence of): Examiner PULMONARY HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit VALVULAR HEART DISEASE Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 Yes 2 g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ACUTE RENAL FAILURE 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Yes 2 X N 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Yes 2 💢 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner, to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title D 31189

State Registrar

W DHMH 17 Rev 7/2009

M.D.,

32. Registrar's Signatu

7601 OSLER DRIVE, TOWSON, MARYLAND21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MININSOHN,

MICHAEL J.

CT 26

Day, Year) 2010 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of M				t of H	ealth a	and M	lental Hy		0	0	33503	3
-	Disconical		Decedent's Name (First, Middle, I	ast)					·		2. Date of De	eath Day		/ear	3. Time of Death	
>	Physici /Medio Examir	al	4a. Fecility Name (If not institution, g	Linda		Cowar			ell Location	of Death	October	19	, 20 County of	10	10:54 8	M
			Union Memoria		al			tim					na			
	Funeral		Social Security Number     6.	Sex 7. A( 1 M 2√0√F		last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 12-1	rth a <u>y,</u> Year)	9	9. Birthp Cour		ign
	Director		212-56-9051 Usual Residence of Decedent	WAY.	58	Yrs.					12-1	5-19	951		MD	_
	and		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							1	0d. Inside City Limi	its
	Mary	ō	MD	~ ~	Pa	ltimo	***								1 X Yes 2 □ N	No
	the 28.	Je C	10e. Street and Number	na	ра	LLLINC	10f. Zip	Code				10a. Citiz	zen of Wh	at Cour	ntry?	
	3e or	0	1527 Montpel	ier Stre	et			218			į	-	JSA		,	
	death	by Funeral Director	11. Marital Status	12. Was Decedent	Ever in U	.S. 13.			spanic Ori	gin? (Sp	ecity Yes or No Rican, etc.)		14. Race		an Indian,	
9	or the	Ē	1 Never Married 2 Married	Armed Forces  1  Yes 2  If Yes, Give	? No						Rican, etc.)			White,		
03	rai', c	<u>5</u>	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:			1□Yes 2	ZX_I No	Specify:				Specify:	вт	аск	
215-0036	within 72 hours efter death with the Maryland ene. then "netural, or iteme 23e or 28e-f ehow its Madical Exemiter must be notified at	Completed	15. Decedent's (Specify only highest of	Education trade completed)		16a. Dece	dent's Usua	l Occupa	ation during mos	t of work	ina	16b. Kir	nd of Busi	ness/In	dustry	
21	ithin	현	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of wor DO NOT us				9	Env	/iro	nme	ntal	
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<u>n</u>	be fit d off	Be	17. Father's Name (First, Middle, La.								(First, Middle	, Maiden .	Sumame)	)		
yla	should be nd Mente marked matic ev	ို	Rudolph MacKe								ones					
Maryland	2 0 0 0		19a. Informant's Name/Relationship			I consequence		500			al Route Numb	er, City or	Town, St	tate, Zip	Code)	
-	s 1 end f Heaith Item 27 other to		Myrina B. Cov	art-daug	hter	1527	Mon	tpe.	lier	St	reet				21218	
ō	Peges 1 nent of H ant: If Ite ary or ot		20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3	Removal from State		Place of Dispo cemetery, crea	matory or o	ne or ther plac			Date			-	own, State	
Ë	tant:		`4 □Donation 5 □Other (Spec		Gr	eenmo					2-2010				, MD	
Baltimore	permit. Peges Depertment of Important: If It eny Injury or o		21. Signature of Funeral Service Lio	ensee TCK-9	me		2. Name and 101			-	March zenue			50	21202	
760,	Physician hysician physician physici	ical Examiner	23a. Part1. Enter the disease, or co shock, or heart failure. List on immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. First Inderlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as	often	uence of):	bolky c	, , .		cardiac	r respiratory a	irrest,	,		Approximate Interval Between Onset and Death 45 Miles Good Street Constitution of the April 1997 Ap	
P.O. Box 68	The law requires thet the deeth certificet ale has been signed by the attending phy bage 2 should be detached for use as the	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	I death 3	Ectopic pro					2	3d. Date Monti		ary Day Year	
	quires thei n signed b uid be det		Part II. Other significant conditions	contributing to death t	out not res	ulting in the u	nderlying ca	ause give	n in Part I			tobacco u: Yes 2 [			ne cause of death? ably 4 []Unknov	٧n
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of Vital	Physicien: this certific rai director,	ToB	examiner? ↑ÇM'es 2 ☐ No	Hospital: 1 Inpati	ent 2)X	ER/Outpatier	nt 3 DO	A Othe			me 5□Resi		Other	(Specif	y)	
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Division	To the Hospitel or Attendi within 24 hours elter death. To the Funeral Director: A completely filled in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		jury - At ho tc. (Specif	ome, farm, str	eet, factory	, office			28f. Location ( City or To			or Rura	i Route Number,	
	To the Hospitel or within 24 hours elte To the Funeral Dirac completely filled in I	Medical	29a. Certifier Certifying I (Check only one) 2 Medical Ext	Physician: To the best aminer: On the basis of and manner st	of examina	wledge, death	n occurred a vestigation,	at the tim in my op	e, date an pinion, dea	d place, th occurr	and due to the ed at the time,	cause(s) date and	and manr place, an	ner as si	tated. the cause(s)	
	To th To th	×	29b. Signature and title of certifier		-		29c	. License	number			29d. Date	signed (	Month,	Day, Year)	
			▶ PXM	Mi					166	911	4	2007	-0/	سر، د	19 201	1
			30. Name and address of person wh	completed cause of	death (Iten	n 23a) (Tyne	Print)	ب ب		110			1000	_Y	11, 001	J
			Patricia	Ann 1		dden	ih	00/	Mer	no-	ial H	USD!	tal	. 1	Baltimore	e .
	Sta Registr	_	31. Date filed (Month, Day, Year) OCT 26 2010	32. Regist				, – ( )	. , , , ,			- P1	1001		1	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 1<sup>0</sup>9, 2010 4:45 P M Salmon, Jr. <u>Walter</u> Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 13822 York Road Cockeysville BaltimoreIf Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex **Funeral** Month, Day, Ye.

≥b 11, 1 Months Min. 1 **X** M 2 □ F Yrs. **Director** 215-05-6091 90 Feb Pennsylvania Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic actions. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🗶 No <u>Maryland</u> Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13822 York Road 21030 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ⚠ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 X Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 08 n/a <u>Upholstery</u> <u>Upholsterer</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Salmon, Sr Rose Flowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy D. Bock/Daughter 10525 Wilmar Place, Cockeysville, MD 21030 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Demation 5 ☐ Other /Spe#ff/t # 10/2<sup>Date</sup> cemetery, crematory or other place) Demotion 5 Other (Specify) Dulaney Valley Memorial Gardens Timonium, Maryland Bryan W. Clary 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 23a. Part 1 Inter the disease, or complications that, aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only on cause on fach line. Approximate ATHEROSCUROTIC Interval Between Immedia Cause (Inal Onset and Death Physician/ CORFBROW ASCULAD disease condition resulting in ) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner rany, reading to inmediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence or; the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 🗌 Yes eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: ၉ 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de To the Funeral Director completed filled in by t Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

DHMH 17 Rev 7/2009

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) OCT 26 2010

Jeffrey Alexander,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

M.D., 120 Sr. Pierre Drive, Suite 101, Towson, MD

29d. Date signed (Month, Day, Year) 10/21/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 33505 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ Virginia F. Stevenson 2.QA Medical October 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Balto. Timonium Stella Maris Hospice 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Days Hours Min. (Month, Day, Year) 89 156-07-6374 **Director** Maryland December Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland event, the Medical Examiner must be notified at Director Bowley's Quarters Balto. Md. 1 Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral items 23a USA 21220 934 Susquehanna Avenue hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō Completed by 1 Never Married 2 Married ☐ Yes 2 🗓 No 215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural". 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) within 72 than Elementary/Seconday (0-12) College (1-4 or 5+) Home <u>Homemaker</u> other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental 2 Daniel G. Huntsberger Frances Jumper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR. Department of Health Important: If item 27 Patricia Byron 934 Susquehanna Avenue Bowley's Quarters, Md. injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Page 1 cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-23-2010 Balto. Md. Oaklawn Cemetery 22. Name and Address of Facility <sup>ime and Address of Facility</sup> Schimunek FuneralHome 9705 Belair Road Nottingham, Md, 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CEREBROVASCULAR ACCIDENT disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L Fetal dea 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year 5 Other (specify) Month Day 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 X No 1 🗌 Yes Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 🗌 Yes 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work 2 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Mginth, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

DHMH 17 Rev 7/2009

State Registrar

OCTOBER

STEVENSON

VIRGINIA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33506 Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 24,2010 Ye Physician/ Month Vincent L. Stevens October 0 10:53A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner <u>Gilchrist</u> Towson 8. Date of Birth
(Month, Day, Year)
May 8,1931 6. Sex 1 X M 2 ☐ F If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Mary Land Director 79 Yrs. 219-28-4404 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits 1 Yes 2 X No Md. Balto. Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14 Avonmore Court 21128 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bethlehem Steel Welder Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Vincent J. Stevens Rosalie Lupinek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Stevens Spouse 14 Avonmore Court Perry Hall, Md. 21128 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 💢 Burial 2 □ Cremation 3 □ Removal from State Gardens of Faith 10-27-2010 Balto., Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Frieral S. Arcel See 22. Name and Address of Facility Schimunek Funeral Home 1 4 9705 Belair Road Nottingham, Md, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Priysician, astro intesta WEEKS ) Medical resulting in death) he to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ate has been signed by the atte page 2 should be detached for Month Day Year Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate 2 No 1 🗌 Yes Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) WWW. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Alatural 2 Accident 3 Suicide 5 Pending work' To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier 29d. Date signed (Month, Day, Year)

& X/

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AAVON J CHANCES M 670(N.Chayles)

32. Registrar's

58303

OCTUSED 24 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ P<sub>M</sub> Samuel Staten 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 4403 Kildare Ct. Aberdeen Harford Social Security Numbe If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)

New Jersey 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 59 Months Days Hours May 9, 1951 148-42-4110 Director Usual Residence of Decedent shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford 1 Yes 2 No Ahemben 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21001 4403 Kildare Ct. U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 M Married ğ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Computer Engineer Telecamunication Verizon 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick Staten Queen Elizabeth Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Dorothy Sharon Staten (Spouse) 4403 Kildare Ct. Aberdeen, Maryland 21001 20b. Place of Disposition (Name of cemetery, crematery or other place Evans Funeral Chapel-Bel Air 20a. Method of Disposition October 24, 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 2010 Forest Hill, Maryland Signature of Funeral Service Licensee Jeffrey R. Testerman 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services Bel-Air (M01543)3 Newport Drive, Forest Hill, Maryland 21050 Part I. Ehler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ANG OCAR CLOVE Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 2 🖪 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner To the best of my knowledge ideath occurred at the time date and place and due to the 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BERNHARD 3174 BIRND MATA 103 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 6:40 A M Dorothy May Seekford October 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Manor Care-Towson Baltimore Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Months Days Hours (Month, Day, Year) 1 □ M 2 🔽 F Mary Land 220-07-1901 88 Yrs **Director** May 19 Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits FL Indian River Vero Beach 1 Yes 2 XNo 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 1565 19th Street SW 32962 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married ☐ Yes 2X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: White Specify: Completed 3 X Widowed 4 Divorced Il Hygiene. other than "natura vent, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) 1 2 Home College (1-4 or 5+) Homemaker it. Page 1 and 2 should be filed withinthent of Health and Mental Hygienratant: If item 27 is marked other thoury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Norman Chalk Thelma Sipes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1565 19th Street, Vero Beach, FL 32962 Denise Dix/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it any injury or o October 1 X Burial 2 Cremation 3 Removal from State Timonium, Maryland 25, 4 ☐ Donation 5 ☐ Other (Specify) 2010 Memor Signature of Funeral Service Licenses <sup>22. Name and Address of Facility</sup>
Evans Funeral Chapel & 8800 Harford Road, Park Cremation Services 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. EMEN TIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying spital or Attending Physician: The law requires that the death certificate be executed ours after death.

eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal deat
Pregnant at time of death
Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? 1 Yes 2 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? No No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4. Nursing Home 5 Residence 6 Other (Specify, 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a hours Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. re and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) Crad 881 WOND 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 262010

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State 33509 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death CFO be Physician/ Year Anne Goodhue Simmons 40 P.M 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Juseph OWSON If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Balt., Maryland 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** 1 M 2000 Days Hours Min. Months January 7 86 220-20-9239 Director Maryland Usual Residence of Deceden 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Phoenix 1 Yes XX No 10e. Street and Number 10g. Citizen of What Country?
United States 10f. Zip Code Funeral 14530 Manor Road 21131 of America 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: white Completed 3 Widowed 4 Divorced Specify: 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Fashion designer Garfinkle's Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marion Goodhue Sarah Roszel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Raymond S. Simmons, III 14530 Manor Road Phoenix, Maryland 21131 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State October Evans Funeral Chapel – Bel Air 1 ☐ Burial 2 🛭 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Forest Hill, Maryland . Signatur of Funeral Service Licensee Peace 101 Alternatives Funeral and Cremation Center, P.A. to 232<u>5 York Road Timonium, Maryland 21093</u> Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death disease or condition resulting in death) Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 🖪 No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1  $\square$  Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 2 No 2 🗌 No Yes 26. Place of Death (Check only one)

Physician/ Medical Examiner

burial-transit

signed by the attending physician does detached for use as the burial

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Medical

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that the death certificate be executed

Division of Vital Records, P.O. Box 68760

or Attending Physician: The law requires

Hospital

shov

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 275 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at

Maryland 21215-0036

Baltimore,

the Certificate: To Be e Hospin...
in 24 hours after death.
the Funeral Director. After this of

25. Was case referred to medical 2 No 1 Yes Manner of Death

1 X Natural Accident Suicide 4 Homicide

29a, Certifier

(Check

only one)

6 Could not be

1 Natient 2 ER/Outpatient 3 DOA 5 Pending Investigation determined

28a. Date of injury (Month, Day, Year)

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Other:

1 Tes

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 🗌 No

28c. Injury at

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 KCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

TOWSON, Maryland

28d. Describe how injury occurred

4 Nursing Home 5 Residence 6 Other (Specify)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year, 10-22-

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 26 2010

29b. Signature and title of certifier

32. Registrar's Signature

Registrar DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Katherine Sousa - Smith 13:54 October 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Upper Chesapeake Medical Center Harford County Bel Air 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □**X**F Months March 9 215-68-1702 54 Director Maryland Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford County Joppa 1 🗌 Yes 2 🔀 No 10f. Zip Code 10g. Citizen of What Country? Funeral 215 Haverhill Road 21085 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🖾 No Specify: Specify: White If Yes Give 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) N/A Elementary/Seconday (0-12) Homemaker Own Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elva K. Kiernan Antone J. Sousa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Colby Smith (Husband) 215 Haverhill Road, Joppa, Maryland 21085 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🎇 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Parkville, Maryland 10/28/2010 Parkwood Cemetery 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services-BelAir
3 Newport Drive Forcet Hill 21. Signature of Funeral Service Licensee Scar Les Forest Hill Maryland 21050 Newport Drive, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) , Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be after death. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No
9 Unknown Year Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records. 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed After this certificate har funeral director, page 1 ☐ Yes 2 No Division of Vital 25. Was case referred to a edical æ 26. Place of Death (Check only one) Hospital: Other: မြ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 24 hours Funeral Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Exertine: On he basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Number Practicing to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier and address of person who completed cause of death (Item 23a) (Type, Print) filed (Month, Day, Year)
0CT 2 6 2010 State 32. Registrar's Signature Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Month <sup>Day</sup> 24 Physician/ Edward Shaffer, Sr. 2010 9:56 Carl October Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 16929 Yeoho Road Baltimore Parkton 8. Date of Birth (Month, Day, March 20, 9. Birthplace (State or Foreign Country) Maryland Year If Under 24 Hrs.
Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Davs 1 🕅 M 2 □ F 83 Director 212-22-5337 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State must be notified at Director 1 ☐ Yes 2 No Maryland Baltimore Parkton 10g. Citizen of What Country? 10f. Zip Code 5 10e. Street and Number 23a Funeral United States of America 16929 Yeaho Road 21120 ural", or items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2XX No Specify: If Yes, Give "natural", Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Sha-Hill Farm 12 Farmer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Gladys Mays should be Edward A. Shaffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16929 Yecho Road, Parkton, Maryland 21120 Health tem 27 Mary P. Shaffer - Spouse Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. cemetery, crematory or other place)
Int Carmel United
Thodist Church Cemetery 1 X Burial 2 Cremation 3 Removal from State Parkton, Maryland 10/27/2010 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Evans Funeral Chapel and Cremation Services - Monkton
16924 York Road, Monkton, Manyland 21111 Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition a... Approximate val Between Or ser and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last physician Be Completed by Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 attending properties for use as IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year 1 Yes 2 No ed by the a 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Carchevascular dx 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? Coronay artey dx. 24a. Was an certificate has be irector, page 2 s performed? Yes 2 ☑ No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 👿 No မ 4 Nursing Home 5 N Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred ¥ Natural 5 Pending 1 Tes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deat Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Hospital K. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 Mark Cames W 03452 10.25.10 Name and address of person who completed cause of the att (item 633) (Type Mank Lambo Mo 9 Schulling Rd 21031

Registrar
DHMH 17 Rev 7/2009

State

32. Registran Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3351 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year <u>10:</u>30₽™ John M. Seney, Jr. 2010 October Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2501 Monkton Road Monkton Baltimore 5. Social Security Number . Sex 1 XXM 2 □ F 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland Months Days Hours (Month, Day, Year) 28, 1925 219-10-6724 85 Director Feb. Usual Residence of Decedent Items 23a or 28a-f show ner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Baltimore Manktan MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ortant: If item 27 is marked other than "natural", or items 23a o injury or other traumatic event, the Medical Examiner must be Funeral 2501 Mankton Road 21111 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black White etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 XNo Specify: White Specify: 3 ☐ Widowed 4 🄀 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Self-Employed Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mildred Moog John M. Seney, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2501 Mankton Road, Mankton, Maryland 21111 Mary Byers - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemeter, crematory or other place)
Evans Funeral Chapel and
Cremation Services-Belair 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services - Monkton York Road, Monkton, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Priysician/ ROIVAR Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transi EMENT and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No been signed by the atte should be detached for 5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 🗌 No 1 🗌 Yes Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Dertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

3346

32. Registrar's Signature

PAPER

HOENIX

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MASSAR

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** P M 2010 October 8:00 Luther Spence /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 210 Crain Highway 3rd floor Glen Burnie Anne Arundel 5. Social Security Number 217-46-3725 If Under 1 Year | If Under 24 Hrs. | 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year **Funeral** Months Days Hours Min. 1 **□X**M 2 □ F 61 W/V Director 10, 1949 Apr. Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits ed other than "natural", or Items 23a or 28a-f show event, the Medical Examination at the notified at MD Anne Arundel Glen Burnie 1XYes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 210 Crane Highway South, Apt. H USA Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ƊXYes 2 □ No Army
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White þ 1 ☐ Yes 2 📉 No Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Painter Service 12 17. Father's Name (First, Middle, Last)
Walter Spence permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Surname)
Ruby Ward Be ၉ 19a. Informant's Name/Relationship (Type. Print)
Gary M. Spence / Brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 581 E. Lincoln Ave., LaBelle, FL 33935 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Final Journey Crem. 10/26/2010 Woodbine, MD 4 □ Donation 5 □ Other (Specify) of Funeral Service Sicensee Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD llowshiall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** read and month disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) 1 □Yes 2 □No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 □Yes 2 No 2 🗗 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 Residence 6 ☐ Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 25/2010 10576136 Name and address of person who completed cause of death (Item 23a) (Type, Print) Baitimure Mb 21201

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registra 's Signature

5. Greene St.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	aryland /	/ Depa <i>Cer</i>	artment of F tificate of L	lealth and Death	Mental Hy	giene <sub>Reg.</sub> No		33514
	Physicia	an/	1. Decedent's Name (First, Midd	le, Last)					2. Date of Dea			3. Time of Death
	Medi	cal	JULES IAN  4a. Facility Name (if not institutio				4b. Citv. Town, or	.l tio t D	LOCTOBE	2	2 2010	4:05 A M
_	Examir	ier		-			, ,	ERSTOWN	ıtn	4c.	County of Deat BALT	IMORE
I	Funeral Director		5. Social Security Number 216-50-2601		e (In yrs. last b	b <i>irthd</i> ay) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min			g. Bir	thplace (State or Foreign untry)
	d It	L	Usual Residence of Decedent  10a. State 10b. County	N/	10c. City, To	nun or l oa	etion					
	larylar 3a-fsk iffed a	Director		ΙMORE	100. Oily, 10	JWII OF LOC		RSTOWN				10d. Inside City Limits 1 ☐ Yes 2 XXNo
	a or 20 be no		10e. Street and Number				10f. Zip Code			10g. Cit	izen of What Co	
	th with ms 23 must	Funeral	5 TIMBER WAY C					1136			USA	
က	er dea or itel niner	by Fu	11. Marital Status 1 ☐ Never Married 2 🛣 Ma	12. Was Decedent E Armed Forces? 1 Yes 2XX		If	/as Decedent of Hi Yes, specify Cuba	n, Mexican, Puer			<ol> <li>Race - Ame Black, White</li> </ol>	
ğ	urs aft :ural", al Exal		3 Widowed 4 Divorce	If Von Cive		1	☐ Yes 2XX No	Specify:			Specify:	WHITE
15	72 ho n "nat Aedica	Completed	(Specify only high	ent's Education lest grade completed)	16	(Give k	ent's Usual Occupa ind of work done d		orking	16b. Ki	ind of Business	Industry
212	within giene.		Elementary/Seconday (0-12)	College (1-4 or 5	i+)		) NOT use retired) PHYSICIAN	<u>'</u>		1	MEDICIN	E
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (First, Middle,	•					ame (First, Middle, i			
3	should be file n and Mental I 7 is marked o raumatic eve	ľ	THOMAS  19a. Informant's Name/Relations	SCHERR ship (Type, Print)	11	9b Mailine	Address (Street a	IRENE	ural Route Number		IED Town State Zir	n Codel
ž	and 2 sh Health a em 27 is ther trai	3	BONNIE SCHERR	≀/WIFE					REISTERS1	-		*
ore	Page 1 ar ment of Ha ant: If iter ury or oth		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation	3 Removal from State	ceme	tery, crem	ition (Name of atory or other place	•	Date		ocation - City or	
ij	nit. Pa lartmer ortant injury		4 Donation 5 Other (		BALTI	MORE	HEBREW C	EM. 10/	24/2010	REIS	STERSTO	WN, MD
ä	permit. Departn Importa any inju		Michael	Bruge	_	390	O REISTE	RSTOWN	OL LEVINS ROAD, PIK	(ESV	ILLE, M	d 21208
				r complications that caused only one cause on each line	the death. Do	o not enter	the mode of dying	g, such as cardia	c or respiratory arre	est,		Approximate Interval Between
	Medical		Immediate Cause (Final disease or condition resulting in death)	a. HEUTE Due to (or as a			EDUL	INS	ARCTIO	M		Onset and Death
	Examiner	<u>.</u>	Sequentially list conditions	ALTERIOS			HEART	DISTA	3E			10 years
	ed sit	Examiner	if any, leading to Immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a		•						15 years
	execut an and ial-trar		that initiated events resulting in death) Last	Due to (or as a								1 Jeans
09,	certificate be executed nding physician and use as the burial-transit	edical		d								
687	sertifica Iding p		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnancy						and Date of del	
Rox	r requires that the death certific been signed by the attending should be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live Birth 4 ☐ Pregnant at	2 🗌 Fetal dea		Ectopic pregnancy Other (specify)	y 		4	23d. Date of del Month	Day Year
0	at the of the of the etache	Phys	g ☐ Unknown  Part II. Other significant condition	9 Unknown	it not reculting	a in the un	derlying cause give	en in Part I	00 - B'-11-			
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ö	w requisite been 2 shou	Completed	Rense W	SUFFICIENCE	1				24a. Was a		24b. Were aut	topsy findings available
ě	The la	Sol							autops perfor 1 \(\sum \) Yes		death?	completion of cause of
<u>ra</u>	sician: certific rector,	Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital;			Other	ce of Death (Che	eck only one)			
or Vital Records,	g Phys er this eral di	e: To	27. Manner of Death	28a. Date of injur		. Time of	28c. Injury	4 □ Nursing I at	dome 5 Reside			fy)
0	tendin leath. or: Aft the fun	Certificate:	1 Matural 5 Pendir 2 Accident Investi 3 Suicide 6 Could	gation	Year)	injury	M 1 □ 1	yes 2 □ No				
DIVISION	al or Att after d Direct d in by		4 Homicide determ		ry - At home, t . (Specify)	farm, stree	et, factory, office		28f, Location (St City or Town		Number or Rur	ral Route Number,
	To the Hospital or Attending Physician: The law requires that the whom the Houver after defined by the Torthe Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	Medical	(Check 2 L Medical E	p Physician: To the best of r Examiner: On the basis of ex Nurse Practionar: To the	amination and	Vor investic	ation. In my opinior	<ol> <li>death occurred.</li> </ol>	at the time, date an	d place	and due to the c	ause(s) and manner stated
	To the complete compl		29b. Signature and title of certifier	ATT	EN DING	, , 31	29c. License	number			e signed (Month	
)		Sogs			HSICIA			1155		OCT.	22,	2010
			30. Name and address of person Acritics L. Rui	wno completed cause of de	ath (Item 23a) Block	(Iype, Pri	NESTA	11,11570	2 MEXI	آ ل	> 211.	57
	State Registra		PETTUR L. RUS 31. Date filed (Month, Day, Year) OCT 2	6 2010 32. Reg. rar	's Signature	b. A	face		,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Maryla				Mental Hygi	ene	0 00515
			State Registrar		Cer	tificate of L	Death		g. No. 2010	J 33515
	Physicia		1. Decedent's Name (First, Middle, Last)	,				2. Date of Death Month	Day Year	3. Time of Death  1 • 17 D M
	Medic Examin		4a. Facility Name (if not institution, give s			4b. City, Town, or	Location of Deat	IOCTOBER	21 2010 4c. County of Dea	
-60	)		GILCHRIST HOSP	ICE CARE			TOWSON			IMORE
A	Funeral Director		5. Social Security Number 6. Sec. 216-33-1067	X 7. Age (In yr	rs. last birthday) 7 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		9. Bir	ountry) UKRAINE
	ind show	5	Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Loc	cation	- 1112			10d. Inside City Limits
	Maryla 28a-f t otified	Director	MD BALTI	MORE	BAL	T IMORE				1 □ Yes 2 <b>X</b> No
	th the 3a or 3		10e. Street and Number			10f. Zip Code	222	10	g. Citizen of What Co	*
	ath wil	Funeral	16 JONES FALLS TI	ERRACE 12. Was Decedent Ever in	11.0 13.V	Vas Decedent of Hi	209	booth, Vee or No-	US.	
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 3 X Widowed 4 Divorced	Armed Forces?  1 Yes 2 Y No If Yes, Give Year or Dates.	lf lf	Yes, specify Cuba	n, Mexican, Puer		14. Race - Ame Black, Whit	
15-(	72 hou n "nat ledica	Completed	15. Decedent's Ed (Specify only highest grad		(Give k	ent's Usual Occup- ind of work done of		rking 1	6b. Kind of Business	Industry
212	within jiene. er thai		Elementary/Seconday (0-12)	College (1-4 or 5+)		NOT use retired)  VALITY CO	NTROL		MANUFACTI	URING
pu	filed v tal Hyg d othe	o Be	17. Father's Name (First, Middle, Last)					me (First, Middle, Ma		
ryla	uld be d Ment marke matic	2		CHAIM	-1		UNKNOW		UNKNO	
Ma	12 shoulth and 27 is retraur		19a. Informant's Name/Relationship (Typ. NELYA STATNIKOVA)		1				ORE MD 2	
ore,	of Head of Head fitem rothe		20a. Method of Disposition	201	b. Place of Dispos	sition (Name of			Oc. Location - City or	
Baltimore,	Page tment tant: I	- 1	1) ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify)	)_	CHIZUK	ON CEMET AMUNO	10/2	4/2010 B	ALTIMORE.	MD
Ball	permit Depart Import any inj	7	21. Signature of Funeral Service License	el	89 89	Name and Address	ss of Facility SO ERSTOWN	L LEVINSOI ROAD, PIK	N & BROS. ESVILLE, 1	INC MD 21208
	Physician/	0. 3	23a. Part 1. Enter the disease, or compl shock, or heart failure. List only one Immediate Cause (Final disease or condition	lications that caused the de e cause on each line.						Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a cons			,			1
	ted Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as a cons	equence of):					
	icate be executed physician and s the burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as a cons	equence of):					
09	ate be hysici the bu	edical		d						
Division of Vital Records, P.O. Box 68760	eath certifica attending p	Physician/Me	in the past 12 months?	3c. If yes, outcome of preg 1 ☐ Live Birth 2 ☐ F 4 ☐ Pregnant at time of	etal death 3 🗌	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	blivery Day Year
Ö.	the degraph of the a	hysi	1 🗌 Yes 2 🔲 No 9 🗍 Unknown	9 Unknown	or death o	Other (Specify)				
ds, P.C	quires that i	by	Part II. Other significant conditions cor	ntributing to death but not	resulting in the un	nderlying cause giv	en in Part I.	23e. Did tobac	cco use contribute to	o the cause of death? Probably 4 🗆 Unknown
SCOL	law rec has bee	Completed						24a. Was an autopsy performe	prior to	topsy findings available completion of cause of
= E	Physician: The lav r this certificate haveral director, page 2		25. Was case referred to medical			26 Dia	ace of Death (Che	1 🗆 Yes 2		s 2 🗆 No
Vita	ysicia is cert direct	To Be	eyaminer? .	lospital:	☐ ER/Outpatient	Othe			ce 6 10 Other (Spec	inhosplip
on of	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Certificate: 1	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of injury (Month, Day, Year)	28b. Time of	28c. Injury work	at	28d. Describe how		(1)
Divisi	ital or Atta		4  Homicide determined	28e. Place of Injury - At building, etc. (Spec	cify)			City or Town, S	·	·
	he Hospi in 24 hou he Funei ipleted fil	Medical	(Check 2 Medical Examine	cian: To the best of my kno er: On the basis of examina Practioner: To the best of	tion and/or investi	gation, in my opinio	n, death occurred	at the time, date and p	place, and due to the	cause(s) and manner stated.
	Noth Com	_	29b. Signature and title of certifier			29c. License	number 8303		d. Date signed (Month	
			30. Name and address of person who co	mpleted cause of death (It	em 23a) (Type, Pr	int)			FORCE 21	\
B	Stat Registra	Ç	31. Date filed (Month, Day, Year)  OCT 26	mpleted cause of death (It	nature A.	bare	1 000,000	, , , , , , ,	-0/V (* CT)	,

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 33516 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Morth 3. Time of Death Physician/ 730M ULIAN Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7512 Crofton Colony Drive Crofton Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Virginia **Funeral** Date of Dis... (Month, Day, 1 **X**M 2 □ F Months Days Hours Min. Director Yrs 578-48-3350 936 Usual Residence of Decedent or 28a-f shov artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Completed by Funeral Director 10d. Inside City Limits 1 X Yes 2 □ No Maryland Anne Arundel Crofton 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 7512 Crofton Colony Drive USA 21114 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, med Forces? Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. 3 🗆 Widowed 4 🗆 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Government Employee Defense Mapping Agency Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Freddie Terry Rebecca Fitzgerald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Monica Terry/ Daughter 6321 Red Haven Road Columbia, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or oth 20c. Location - City or Town, State Baltimore Washington<sub>10/22/2010</sub> Laurel, MD 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ homa disease or condition Medical resulting in death) e to ( as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last burial-transi Due to (or as a consequence of): signed by the attending physician I be detached for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, cate has been signated to page 2 should to Completed 1 ☐ Yes 2 🗖 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed To the Hospital or Attending Physician; The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 2 🗀 No 1 Tes Yes 2, KN 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 
Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifie 29c. License number Name and address of person who compl di cause of death (Item 23a) (Type, Print) EFENSE HWY ICHAEL 441 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 9:30 AM Rudolph Thomas 2010 10 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hospital Union Memorial timore Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1**x** M 2 □ F Year) Hours (Month, Day, Country) 69 SC 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits MD NΔ Baltimore 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 832 North Carey Street 21217 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. 1 Yes 2 No Specify. Black ₩ Widowed 4 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Southern lementary/Seconday (0-12) College (1-4 or 5+) 11th grade Machine Operator Gal Janizing Co. na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Thomas Rosebelle Blyther 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy Thomas-Son Carey Street, North Baltimore, Md 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) Memorial Park 10/27/2010 Woodlawn, Md Signal und f Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Av Ave Baltimore. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Asystole and disease or condition resulting in death) Diadycardia Z hours Due to (or as a consequence of) Endocarditis Directo (or es a nonsequence of) End Stage Renal Due to (or as a consequence of)

Physician/ Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician/

Medical

Director

Funeral

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Be Completed

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Examiner

Funeral

Director

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notified

must be 23a

filed within 72 hours after death with the Maryland

3altimore, Maryland 21215-0036

Page 1 and 2 should be filed within 7: nent of Health and Mental Hygiene. ant: If item 27 is marked other than

traumatic

other

Department of Important: If it any injury or o once.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner that initiated events resulting in death) Last Physician/Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) g ☐ Unknown		23d. Date of o	delivery Day	Year
Part II. Other significant condition	is contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco			
		_ 1 LJ Yes	? □ No 3 □	Probably 4	↓ <b>X</b> Unknown
		24a. Was an autopsy performed?	prior to death?	o completion	ngs available of cause of

2010

ted by	- Street significant conditions of	ontributing to death but not re-	sulting in the underlyin	ig cause given in Part I.		se contribute to the cause of death?  No 3 Probably 4 X Unknow
Complete					24a. Was an autopsy performed? 1 □ Yes 2 ▼ No	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
Be	25. Was case referred to medical examiner?		1,070,1	26. Place of Death (Che	eck only one)	
2	1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 🗌	DOA Other: 4 \( \sum \) Nursing I	Home 5 Residence 6	☐ Other (Specify)
Certificate:	27. Manner of Death  1 Matural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred
	3 Suicide 6 Could not b			ory, office	28f. Location (Street and City or Town, State)	l Number or Rural Route Number,
ical	29a. Certifier 1 Certifying Phy	sician: To the best of my know	ledge, death occured	at the time, date and place,	and due to the cause(s) and	d manner as stated.

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) 2438946 19 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Owen

State

within 24 hours a To the Funeral C

31. Date filed (Month, Day, Year) 26 2010 Registrar

Union Memoral

12 2 y

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

STUART

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLES

OCT 26 2010

7601

D 36663

OSLER DRIVE, TOWSON, MARYLAND 21204

29d. Date signed (Month. Dav. Year)

10/23/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death edent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7:22 PM More OCT 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death AGNES HOSPITAL BALTIMORE . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral**  Birthplace (State or Foreign Country) 1 **⋈** M 2 □ F Months Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10d. Inside City Limits Director 1 🗆 Yes 2 🔊 o 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married 1 🗆 Yes 2 **XX**No Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life DO NOT use retired) opnday (0-12) College (1-4 or 5+) lechniciar Be ည hompson, Sr. 19b. Mailing Addres (Street and Num) Windsor Mill. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory of other place) 20a. Method of Disposition Department of 1 Surial 2 Cremation 3 Removal from State Baltimore, MD 10-29-10 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens eenp 23a. Part 1. Ent. title disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he it failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death PNEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Completed by Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events burial-tra resulting in death) Last Due to (or as a consequence of) After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial certificate be IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, HYDROCEPHALUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 9 Hospital or Attending Physician: The law requir 24 hours after death.
9 Funeral Director; After this certificate has been HEMANGIOBLASTOMA 24b. Were autopsy findings available prior to completion of cause of autopsy death? 2 No 1 Yes ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No ٥ 1 Yes Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.D P23748 Oct, 22, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAJANI JAGANA, St AGNES HOSPITAL, 900 CATON AVENUE, BALTIMORE, MD 21229 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

THOM PSON

NO

AMES

State Registrar

29a, Certifier

(Check only one)

29b. Signature and title of

GEORGE JOHN

KATHLEEN

ed cause of death (Item 23a) (Type, Print)

PYRGOS

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D62099

9000 FRANKLIN SQUARE DRIVE BALTIMORE, M.D. 21237

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 25 8:30 AM JULIA ROSE WENGERT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Pasadena Locust Lodge 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral Days 1 🗆 M 2 🔀 F Months Hours 9<sup>Month</sup>5<sup>Day</sup>1<sup>Y</sup>9<sup>n</sup>12 5289 98 Austria 213 14 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State Funeral Director Examiner must be notified 28a-f MD Anne Arundel Pasadena 1 Tes 2 No 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 21122 U.S.A. 184 Meadow Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Yes 2 M No Yes, Give Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 

Widowed 4 □ Divorced White Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Schwartz Julia Anna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 112 Sharon Dr. Pasadena, Charles Hall - grandson item 2 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or otl 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 10 28 10 Overlea, 21. Signature of Egperal Service Licenses 22. Name and Address of Facility GJ Gonce Funeral Home 169 Riviera Drive Pasadena, MD 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardio Vascular Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence on if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician; The law requires that the death certificate be executed anding physician and use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Certificate: To Be Completed by Physician/Medical P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day 1 Yes 2 I significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? nocess Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s autopsy 2 X No 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other (Specify) Hospital Other: 2 🗷 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at work? 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide (Month, Day, Year) injury 5 Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year) 10/26/

State Registrar

DHMH 17 Rev 7/2009

3708 mountain Rd Posodero MD21100

30. Name and aggress of person who completed cause of death (Item 23a) (Type, Print)

hristopher deBoria, m.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First\_Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 406 Nova Avenue Prince Georges Capitol Heights 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) DEC 1, 1936 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Months Days Hours Califo<u>rnia</u> Director 562-50-9943 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland Funeral Director MD Prince Georges Capitol Heights 1 ☐ Yes 2X No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 406 Nova Avenue 20743 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Force Black, White, etc. or, 1 Never Married 2 Married þ 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: "natural" 3 Widowed 4 X Divorced Completed **Black** Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) l Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ပ္ Peter Williams Cleo1a Gamble 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Tamu Seck, daughter 406 Nova Avenue Capitol Heights, MD injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory, Inc. 10/22/10 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility Cremation Society of MD, Inc. 21. Signature of Funeral Service Licensee George MacNabb Sery 299 Frederick Road Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence oi). Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy for in the past 12 m Day Pregnant at time of death 5 Other (specify) 1 Yes 2 No ed by the a 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Watural 5 Pending iniury s after death 2. Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a pleted filled Medical 29a. Certifier crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) within To the 29b. Signature and title of certifier ted cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month

26 2010

egistrar's Signatur

## Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Plea	se Type or Pr State of M										
		For State Registrar	State of iv	ıaryıarı		epartmen Certificate			na ivi		Reg. N	001	0 00500
Dhysisis	~/	Decedent's Name (First, Middle,						0		2. Date of De	ath	2011	3. Time of Death
Physicia Medic	al	Joseph	WASI	110	67		V	17,		Och		2,20%	0 600 PM
Examin	er	4a. Facility Name (if not Institution, Season's Hospi						Location of $1$ stown				c.County of Dea Baltimo	
Funeral		5. Social Security Number		ge (In yrs. la		ay) If Under		If Under 24		8. Date of Bir	th	9. Bir	rthplace (State or Foreign
Director		237-62-7261 Usual Residence of Decedent	I ED IN 2 L.IF	71	Yr	s.		110010		(Month, Da 02/03/	7193	39 No	rth Carolina
land show dat	tor	10a. State 10b. County		10c. Cit	y, Town o	r Location							10d. Inside City Limits
e Mary r 28a-i notifie	Director	MD Balt  10e, Street and Number	imore	C	wing	s Mills				Т	10.0		1 <b>X</b> Yes 2 □ No
with th	eral l	61 Straw Hat R	oad. Apt. 2	A			117				-	Citizen of What Co	ountry?
death items	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S	S.	13. Was Decede	ent of Hi	spanic Origir n, Mexican, I	n? (Spec Puerto R	ify Yes or No- lican, etc.)		14. Race - Ame Black, Whit	
2 hours after death with the Maryland "natural", or items 23a or 28a-f show edical Examiner must be notified at	d by	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 🔀 Divorced	ed 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates.	【No		1 🗆 Yes 2	-					Specify:	Black
hours natur dical E	olete	15. Decedent (Specify only highes	's Education		16a. D	ecedent's Usua Give kind of work	Occupa	ation	of workin	a	16b.	Kind of Business	
thin 72 ene. than '	Completed	Elementary/Seconday (0-12)	College (1-4 or	5+)	liit	e. DO NOT use Truck D	retired)		31 44 OHUIT	g		Retail	
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2 shouth and the and the and the transfer transf		19a. Informant's Name/Relationshi Sharin Nelson	, , , ,									or Town, State, Z	ip Code) , MD 21117
Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygene. ant if fire 27 is marked other than "natural", or items 23a or 28a-f sho ant if fire 27 is marked other than "natural", or items 23a or 28a-f sho ury or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition			Place of D	Disposition (Nam	e of			ate		Location - City or	
. Page tment tant: It jury or		1 ☐ Burial 2 ☐ Cremation 4 🖾 Donation 5 ☐ Other (St		7		Gifts Reg	. '	· .				nover, M	
permit. Page 1 a Department of I Important: If ite any injury or of		21. Signature of Funeral Service Li	censee			22. Name and				-		ts Regi	stry , MD 21076
		23a. Part 1. Enter the disease, or o shock, or heart failure. List or	complications that cause	d the deat	h. Do not							nanover	Approximate Interval Between
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Medical Examiner		resulting in death)	Due to (or as	a consequ	uence of):	:			C				
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequ	uence of):								
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death certificate be ex ne attending physician ed for use as the buria	Medi	IF FEMALE:	J							-			
ath certificate be ex attending physician for use as the burial	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth 4 Pregnant	2 Feta	al death	3  Ectopic p		у				23d. Date of de Month	elivery Day Year
g e g	hysi	1  Yes 2  No 9  Unknown	9 🗌 Unknown	at time of t						1			
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cian: 1 ertifica ector, p	Be C	25. Was case referred to medical examiner?	Hospital:				_	ace of Death	(Check		7	K/A	3 h eca
Physi rthis o rral dire	e: To	1 ☐ Yes 2 X7No 27. Manner of Death	1 ☐ Inpa 28a. Date of inj	ury	ER/Outp 28b. Tim	atient 3 DC	Othe Bc. Injury	4 Li Nurs		ne 5 Resi			diff.
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To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director. After this certificate has been signed by it completed filled in by the funeral director, page 2 should be detach.	Medical	(Check 2 Medical Ex		examination	n and/or ii	nvestigation, in n	ny opinio	n, death occi	urred at t	he time, date a	and plac	e, and due to the	cause(s) and manner stated.
To the within 2 To the Somple	Š	only one) 3 L Certifying 29b. Signature and title of certifier	Nurse Practioner: To the	e best of my	y knowled	lge, death occur 29c.	ed at the License	e time, date a e number	and place	, and due to th	e cause 29d. D	e(s) and manner as late signed (Moni	s stated. th, Day, Year)
		· Coat	ANU		n	0 1	3/	58	76	_ (	<u> </u>	× 2	2,2010
		30. Name and address of person w	ho completed cause of	death (Item	23a) (Ty	pe, Print) SPAv	NA	Lim	B	lud.	Bu	ten	th, Day, Year) Z <sub>1</sub> , Z01/C Z1061
Stat Registra		31. Date filed (Month, Day, Year)	32. Regist	rar's Signat	ture								
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33524 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NATNE 2:14 AM BSR. October 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GLEN BURNZE BALTZMORE WASHINGTON MEDICULL CENTER Arunde tona Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 10/28/1937 1 🔀 M 2 🗆 F Months Davs Hours Min Country) 212-40-5680 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City, Town or Location 1 Tes 2 X No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt 201 313 Oak Manor Drive U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: Specify: White 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Motor Vehicle Elementary/Seconday (0-12) College (1-4 or 5+) Administration Security Guard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Louise Edna Styer Watson James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt 201 Glen Burnie, MD 21061 313 Oak Manor Drive Mrs. Susan M. Watson / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State

10/26/2010

Glen Burnie, MD

or 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at Director Funeral by "natural" Completed traumatic event, the Medical Il Hygiene. Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hy, Important: If item 27 is marked other any injury or other traumant. 2

Physician/

Medical

10a. State

MD

4 Donation 5 Other (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HEZHANG,

31. Date filed (Month, Day, Year)

OCT 26 2010

30) HOSpital drive.

32. Registrar's Signature

Examiner

Funeral

**Director** 

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Physician/ Medical Éxaminer

> attending physician for use as the buria detached þ signed | nours after death.
>
> neral Director: After the funeral of the funeral of the funeral filled in by the funeral filled in the funeral fil

the Hospital or Attending Physician: The law requires that the death certificate be executed

has

24 hours a Funeral E

within 2 To the

Division of Vital Records, P.O. Box 68760

	21. Sonature of Funeral Service Licensee	22. Name :	and Address of Facility 1 eton Funeral	2nd Ave	nue SW Gle	en Burnie, MI
1	23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	Do not enter the mo		or respiratory a		Approximate Interval Between Onset and Death
Examiner	Due to (or as a consequer	nce of):  it in fine  nce of):  Ence;	umonia. shalopathy	000000		Days Days
Be Completed by Physician/Medical Examiner	d	death 3 🗌 Ectopia			23d. Date of o	delivery Day Year
eted by P	Part II. Other significant conditions contributing to death but not result  Acute Renal Failure	ing in the underlying	g cause given in Part I.	1 🗆		Probably 4 D Unknown
Comple	Severe Septic Shock Metastatic Renal Cell Ca	rcinomo	a	perf	opsy prior to formed? death	autopsy findings available o completion of cause of ? 'es 2 🗌 No
Be (	25. Was case referred to medical examiner?		26. Place of Death (Chec	ck only one)		
၉	1 Ves 2 No Hospital: 1 Inpatient 2 Inpatient 2 Inpatient 2		DOA Other: 4 I Nursing H	lome 5 🗆 Res	idence 6 Other (Sp.	ecify)
Certificate: To	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	8b. Time of injury M	28c. Injury at work? 1  Yes 2 No	28d. Describe	how injury occurred	
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)	e, farm, street, facto	ory, office		(Street and Number or F wn, State)	Rural Route Number,
Medical	29a. Certifier (Check only one)  1	and/or investigation, i	in my opinion, death occurred a	at the time, date	and place, and due to th	e cause(s) and manner state
_	29b. Signature and title of certifier		9c. License number		29d. Date signed (Mor	nth, Day, Year)
	1 60 7/2 and	1	00069274		1001000	11 201 -

Glen Burnie,

**ORIGINAL** 

Atlantic Crematory

DHMH IT Res MIDDS

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 11:10 PM DEBRA WEST M 10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL GOOD SAMARITAN BALTIMORE BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** 212.78.9199 1 □ M 2 🛛 F Min (Month, Day, Hours **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location must be notified at Director 10d. Inside City Limits Owings Mills Baltimore MD 1 🗌 Yes 2 🔀 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 2111 MILL LISA be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. n "natural", or iten fedical Examiner r 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed ed other than "natu event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home ttomemaker is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental ပ Kobert D. West I and 2 should be I Health and Mentitem 27 is marked other traumatic e May 19a. Informant's Name/Relationship (Type, Print) ( Quuli for 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TioVanna Faulcon) 8812 Harkate Way Landallstown other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any Injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 29 200 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 10 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Valighu C Greene Funtral Services Vallagen C. 2 andalistan MD Road 23a. Part 1. Enter the t isease, or complications that caused the death. Do not enter the mode of dying, such such a cardiac or respiratory arrest shock, or he at failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sevene Sepsis disease or condition Medical resulting in death) Examiner Csteomyelitis Spine Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Decubitus certificate has been signed by the attending physician and irector, page 2 should be detached for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 🕅 No Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by END STAGE RENAL DISEASE, CORONARY 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? CONGESTIVE HEART FAILURE 24a. Was an autopsy performed? Yes 2 2 No 1 Yes 2 No Hospital or Attending Physician; The Hours after death. Funeral Director; After this certificated filled in by the funeral director, pa 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🔀 No Other: Certificate: To 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c, Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

P.O. Records, Division of Vital

Box 68760

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

maudhan

32. Registrar's Signature

RESIDENT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check

PHYSICIAN

SAMEER CHAUDHARI, 5601 LOCH RAVEN BLVD, BALTIMORE - 21239

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

RES 000

29d. Date signed (Month. Dav. Year)

10/22/2010

29c. License number

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month 00 p M Julia Chrystie Webster 10 9 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FRANKLIN Souare Hospital ROSE BacTimore KOSE da 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** -39-8778 Days Year) Months Hours 1 □ M 2 🗓 F Min. 77 Yrs. **Director** Sep. 1933 NY 067-30-6352 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at NY Tompkins Ithaca Director 1X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 62 Burdick Hill Road 14850 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian. e filed within 72 hours after di al Hygiene. other than "natural", or item Armed Forces?
1 ☐ Yes 2 X No 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2X No If Yes, Give Year or Dates: Specify: Specify: White ģ X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Needlepoint Instructor Service 18. Mother's Name (First, Middle, Maiden Surname) permit, Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 Is marked other any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) Be Thomas Chrystie Virginia Stevenson 19a. Informant's Name/Relationship (Type. Print)
Douglas P. Pitney / 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 54 Mountainview Road, Chatham, NJ 07928 Son 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Final Journey Crem. 10/25/2010 Woodbine, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 21. Signature of Funeral Service Licensee Dorota Marshall llaishian Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician HSpiration Preumonia /Medical resulting in death) Due o (or as a consequence of): Examiner HearT failure Congestive esTIVe Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed ANDXIC Brain Due to (or as a consequence of) Physician/Medical Cardio Imonar 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Ye ar 5 Other (specify) 1 □Yes 2 🗷 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐Yes 2 ☐ No investigation after death Director: 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide filled in 24 hours a 29a Certifier 1 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. g (Check of 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 2

To the I

State Registrar

29b. Signature and title

30. Name and address of person

RING

31. Date filed (Month, Day, Year)

of certifi

Medwin

J

Maryland 21215-0036

Baltimore.

P.O. Box 68760.

Records.

Vita

Division of

wno completed cause of death (Item 23a) (Type, Print)

9000

26 20 10 Registrer's Signature

29c. License number

RES0000

FRANKLIN Square DR Balto md 21237

29d. Date signed (Month, Day, Year)

10-21-2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #11 State of Maryland / Bepartment of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician/ 2024 Wilson Linnion October 2013 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital N/ABaltimore 8. Date of Birth
(Month, Day, Year
Jan 18, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 250-42-5277 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 □ F 81 **Director** 1929 Usual Residence of Decedent 10b. County Baltimore 10c. City, Town or Location Randallstown or 28a-f shov 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No 10f. Zip Code 21133 10g. Citizen of What Country? 9407 Lencrest Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 🔀 Yes 2 🗌 No þ 1 Never Married 2 Invarried Specify: Black Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4XXDivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Campbell Co. Maintance 8th N/A Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Ellie Wilson Sarah Small 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lenora Wilson/ Daughter 1527 W. Fairmont Ave. Balto., MD 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State Garrison Fore VA 11/4/10 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beverly D. Cromartie F/S 2700 Edmondson Ave. Balto., MD 21223 21. Signature of Fun all Se lice Licensee 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death pneumonia mulilobar Physician/ day Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year 5 Other (specify) Pregnant at time of death sate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death?
1 Yes 2 No After this certificate Yes 2 To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖳 PR/Outpatient 3 ☐ DOA မှ 1 Inpatient 2 4 27. Manner Feath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 atural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 7/2009

State

Registrar

30. Name and address of person

Meghan (1) 31. Date filed (Month, Day, Year)

Enst

MD

Checkley

6

ho completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

B19916795

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 4a Facility Name (If not institution, give street and number) County of Death 40. CO N/A 4b, City, Town, or Location of Death amilton Center Itimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign County) Security Number last birthday) 1 M 2 F Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? dialy 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Black 3 ☐ Widowed 4 ☐ Divorced

**Physician** /Medical 1 - For State Registrar

MD

6040

**Physician** /Medical

Examiner

**Funeral Director** 

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exeminer must be notified at

Baltimore, Maryland 21215-0036

Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be execute Division or Vital Records, P.O. Box 68760,

been signed by the attending p should be detached for use as After this certification within 24 hours at er death To the Funeral Director, completely filled in by the f

ted	15. Decedent's Edu (Specify only highest grade	cation	16a. Decedent's U	Isual Occupation	16b.	Kind of Business/Industry
Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Waitres	work done during most of wo Tuse retired)	a	B1/ege
To Be C	17 Father's Name (First Middle, Last) USSEY Gaines			18 Mother's Na	ame (First, Middle, Maid 1 Taines	en Surname)
	19a. Informant's Name/Relationship (Ty	pe. Print) Dung/Son	19b. Mailing Addr	ess (Street and Number or F St Franklin	Rural Route Number, Cit St. Balto	y or Town, State, Zip Code)  MD 2/20/
	20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ R  4 □ Donation / b □ Other (Specify)		Place of Disposition (in cemetery, crematory of tro Crema	Name of or other place)	Date 20c.	Location - City or Town, State
	21. Signature of uneral Serve Lice	l	398	REDHILTON	FUNERAL BALTO	Home P.A. MD 21229
	23a. Parit. Enter the disease, or complished shock or heart failure. List only or immedia e cause (Final disease) ondition resulting in death)	Phei	NMONI	A		Approximate Interval Between Onset and Death
Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to br as a consect  CHRONIC  Due to (or as a consect  Due to (or as a consect  Aupendia	quence of):  DS+TV quence of):  Arte quence of):  euscor	ctive Pulv ry Cisea	nonarey 15C	disease
ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome pf pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3 □Ectopi	c pregnancy (specify)		23d. Date of delivery Month Day Year
npleted by Ph	Part II. Other significant co. ditions con the second seco	illation	, cony	g cause given in Part I.  **Justin 1.  **Jus	1 ☐ Yes  24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
င်	_Cisease				performed 1 Yes 2 ☐	death? 1  Yes \23 No
Be c	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	 ]ER/Outpatient 3□		eath (Check only one)	0 Flotter (015)
Medical Certification: To Be	27. Maymer of Death   Natural 5   Pending 2   Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?  1 Yes 2 No	Home 5 Residence	ijury occurred
Sertifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Special	ome, farm, street, fac	ttory, office	28f. Location (Street City or Town, St	a <i>nd Number or Rur</i> al Route Number, ate)
edical (		sician: To the best of my kner: On the basis of examin and manner stated.				e(s) and manner as stated. and place, and due to the cause(s)
ž	29b. Signature and title of certifier  MARCIA SO	USMAN,	AP .	29c. License number ROST6 Z		Date signed (Month, Day, Year)
	30. Name and address of person who co	empleted cause of death (Ite		Oumore		and 21201

2

State Registrar OCT 26 2010

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #31 Per DVR G908 10/26/10 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Rima В. Zakharyan October Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner 138 Shropshire Court Baltimore Reisterstown 1 Year I If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) If Under 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 M 2 😾 F Days Hours Min. (Month, Day, Months 1934 518-51-7166 Director 76 Aug Azerbajan Usual Residence of Decedent 28a-f show 10b County 10a. State 10d, Inside City Limits filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 10c. City. Town or Location 1 Yes 2 X No MD Baltimore Reisterstown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 138 Shropshire Court 21136 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Was Decedent Ever Armed Forces? 1 □ Yes 2 🔀 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify. White Specify: "natural", Completed 3 ☑ Widowed 4 ☐ Divorced event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. I other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Accounting Δ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental F Important: If item 27 is marked o any injury or other traumatic even once. and Mental a 2 Yefraksiya Nagapetova Bograt Nagapetova 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Artur Zakharyan Son Shropshire Court Reisterstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 x Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/19/10 Reisterstown, Saints Cemetery! 21. Signatury of Funeral Service Licensee 11824 Reisterstown Road 22. Name and Address of Facility ens ELINE FUNERAL HOME Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner stric cancer Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Day as been signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cancel 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? Yes 2 No page death? 2 🗌 No 1 Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No Other: ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) eral Director: After this if 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural iniurv 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

within 24 hours a To the Funeral I

DHMH 17 Rev 7/2009

State Registrar

Medical

4 Homicide

only one

29b. Signature and title of certifier

29a. Certifier (Check

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

227

2

Gushelin

Place

St. Pg

2010 strar's S

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

City or Town, State)

ltimore, MD

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

rreem Abdul A	Ali	State of Maryland / Department of 1- For State Registrar  State of Maryland / Department of Certificate of Cert	f Health and Mei f Death	ntal Hy	/giene	201	0 3353
Physicia edical Examir		Decedent's Name (First, Middle,Last)			2. Date of Dea Month October 1		3. Time of Death 0257 hrs
			4b. City, Town, or Location Silver Spring	n of Death	October	4c. County of De	eath
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 578-64-1385 1XM 2 F 65 Yrs.	Months Days Hour	der 24Hrs.	8. Date of Bi	rth(MM/DD/YYYY) 9.	•
death with the Maryland or items 23a or 28a-f show any must be notified at once.	al Director	10e. Street and Number 11600 Lockwood Dr.	Spring  10f. Zip Code  20904		1	0g. Citizen of What C	10d. Inside City Limits 1 X Yes 2 No ountry?
hours after "natural", Examiner	ted by Funeral	1 X Never Married   2 Married   Armed Forces?   If Yes   3 Widowed   4 Divorced   If Yes, Give Year   1	s Decedent of Hispanic Ories, specify Cuban, Mexicar  Yes 2 X No specify.  's Usual Occupation (Give post of working life. DO NOT	n, Puerto F	tican, etc.)	White, etc	Black
21215-0036 uld be filed within 72 Mental Hygiene. marked other than '	Completed		catessen Se	ervi	ces	Safeway	/ Deli.
2121 ould be fi I Mental I marked ic event,	lo Be	Cicero Satterfield  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing.		eddi	e Terr	ТУ	ato Zin Code)
S E E E		Cicero Satterfield-Father 6801	Allegheny	Ave	,Takon Date	na Park, N	d. 20912
Baltimore, permit. Pages I a Department of He Important: If ite injury or other tr	-	4 Donation 5 Other Specify: Heritage 21 Signature of Funeral Service Licensee 22. Na	Memorial ame and Address of Facility	y 411	19-10 Kenne	M ts vb	TAT
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<u></u> ≱xaminer		or condition resulting in death)  Due to (or as a consequence of):	Cardiomegak	ky an	d Obesi	ty	Death
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		25. Was case referred to medical	20 Diamet D. 11 4		24a. Was ar autopsy perform 1 Yes 2	prior to death?	utopsy findings available completion of cause of es 2 No
Vital ysician: this certif director,		examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3	26.Place of Death (C	Nursing H		esidence 6 Othe	
ding Ph After t After t funeral	.   2	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury				w injury occurred	
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e po per C	٦-	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, f (Specify) apartment comp	lex	S	or Town, State	Spring, Md	ckwood Dr. 20904
To the Howithin 24 F. To the Furcompletely	2	Certifying Physician: To the best of my knowledge, death occurred one)  2 Medical Examiner: On the basis of examination and/or investigation and manner stated.  9b. Signature and title of certifier	, in my opinion, death occu	ce, and due urred at the	time, date an	d place, and due to th	ne cause(s)
		Panel Buthay, MI)	29c. License number O.C.M.E.			29d. Date signed (Mo October 14, 201	
	3	Name and address of person who completed cause of death (Item 23a)     Pamela E. Southall, MD	Penn Street, Baltimo	ore, MD	21201		
State Registrar		1. Date filed (Month, Day, Year)  OCT 21 2010  Cenum 3. Aparl		,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			. For	State of Mary	land / Depa	artment of H	lealth and	Mental Hy	giene	
		1	= State Registrar Amend#20b20cPer	THPGC10-12-10	ar Cer	tificate of L	Death		Reg. No.	23531
Phys	siciar	1/	1. Decedent's Name (First, Middle, Last)	101000				2. Date of De Month	Day Year	3. Time of Death
M	edica	al .	SHRLEY AB 4a. Facility Name (if not institution, give st	JAKAM '		4h City Town o	r Location of Death	10 CTOBE	4c. County of De	
Exa	ımine	er	WASHINGTON HOVEA		TAL	-	WA PARK		MON TO	
Fune	eral		5. Social Security Number 6. Sex	7. Age (In )	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	th 9. E	Birthplace (State or Foreign
Direc	tor	-	578-76-0530	M 2 LAF 56	Yrs.	WOTHING BUYS	Tiodic Timin	Aug. I	y, Year) 1954	DC DC
and show	<u> </u>	5	10a. State 10b. County	100	. City, Town or Lo	cation				10d. Inside City Limits
Maryla 28a-f	ă I	rect	Maryland Prince Ge	orge's			Rive	rdale		1 X Yes 2 ☐ No
nd 21215-0036  filed within 72 hours after death with the Maryland al Hygiene.  d other than "natural", or items 23a or 28a-f sho	e e	Funeral Director	10e. Street and Number			10f. Zip Code	707		10g. Citizen of What	·
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or ite		by F	1 ☐ Never Married 2 🗗 Married	Armed Forces? 1 ☐ Yes 2 💆 No		Was Decedent of H f Yes, specify Cuba		o Rican, etc.)	Black, Wi	hite, etc.
urs aff	EXE		3 🗌 Widowed 4 🗀 Divorced	If Yes, Give Year or Dates.		I ☐ Yes 2 🖰 No	Specify:		Specify: B1	ack
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Ind 21215-0036  Filed within 72 hours after death with the Maryland ital Hygiene.  Ado other than "natural", or items 23a or 28a-f show	yen,		17. Father's Name (First, Middle, Last)		<u> </u>		18. Mother's Nar	ne (First, Middle,	Maiden Surname)	
faryland 212 should be filed within and Mental Hygiene.		ဠ	Andı		r		Bert	ha Mae	Philson	
ore, Maryland 21215-0036  1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. ifem 27 is marked other than "natural".			19a. Informant's Name/Relationship (Type Cecily Anderson -			-			r, City or Town, State, Washingto:	
Te,		1	20a. Method of Disposition	To/	Oh Diana of Diana	cition (Name of	:			
Page 1			1 🖾 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	Removal from State	slepwood	natory or other place <b>Cenet</b> er	ÿ   28f8	Ber 9,	20c. Location - City Washingtor Brentwo	od, Maryland
Baltimore, permit. Page 1 and Department of Hea Important: If item	once.	1	21. Si Juature of Funeral Servica License	all so	1 5 122	. Name and Addre	ss of Facility S1	tewart F	uneral Hom	e, Inc.
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876 tificate ng phy		S S	IF FEMALE:							
Box 687 death certificate attending properties as the property of the property		an/	23b. Was decedent pregnant 23	3c. If yes, outcome of pro	Fetal death 3	Ectopic pregnanc	су		23d. Date of Month	delivery Day Year
. BC ne dea v the a		Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant at time 9 ☐ Unknown	e of death 5 L	Other (specify)			Monar	Day roa
Acords, P.O. Box 6870  Iaw requires that the death certificates been signed by the attending plants been signed by the attending plants as a should be defacted for use as 1		<u>y</u> [	Part II. Other significant conditions conf			nderlying cause given	ven in Part I.	23e. Did to	obacco use contribute	to the cause of death?
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Division of Vital Records, tal or Attending Physician: The law requires after death.  The law recent After this certificate has been signed in twe funeral director, after this certificate has been signed in twe funeral director page 2 should by			27. Manner of Death	28a. Date of injury (Month, Day, Yea	28b. Time of		y at		now injury occurred	ecny)
ION tendir leath. lor; Af		Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be			M 1 🗆	Yes 2 No			
IVIS lor At after of Direct		5 5	4 Homicide determined	28e. Place of Injury - A building, etc. (Sp		eet, factory, office		28f. Location (\$ City or Tov	Street and Number or I vn, State)	Rural Route Number,
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific Completed filled in by the funeral director.		Medical		ian: To the best of my k						
the Ho nin 24 the Fu		Mec		er: On the basis of examiner: To the best						ne cause(s) and manner stated. as stated.
<b>5</b> ₩ ₩ ₩ ₩ ₩ ₩ ₩ ₩ ₩ ₩ ₩ ₩ ₩ ₩ ₩ ₩ ₩ ₩ ₩			29b. Signature and title of certifier	0		29c. Licenso		,	29d. Date signed (Mo	
		-	30. Name and address of person who cor	mpleted cause of dooth	(Itam 22a) (Time F		06905		OCTO BE	R 4 2010
1			·	4000. 760	D CARRE	W HISNU	12, TAKO	ma PAR	K 20912	MHRYLHND
	State		31. Date filed (Month, Day, Year)  OCT 1 3 2010	32. Registrar's	gnaturants	1			1	•
Reg	istra		UCH 1 3 ZUIU X	many 10.	7					

DHMH 17 Rev 7/2009

# NAME ADELS, HARRIETL.

			For State Registrar		ertificate of Death	Reg. N	0010 00500
	Physici	an	1. Decedent's Name (First, Middle, Last)				Day Year 3. Time of Death
ч.	/Media		Harriett Louise Ad		14.00 7 1 0 0 10 10		15, 2010   1:00A.™.
	Examir	er	4a. Facility Name (If not institution, give street a		4b. City, Town, or Location of Death		4c. County of Death
-	Funeral		Reeders Memorial Hom  5. Social Security Number 6. Sex	7. Age (In yrs. last birthda)	Boonsboro  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Washington  9. Birthplace (State or Foreign
ı	Funeral Director		470-20-0015  Usual Residence of Decedent		Months Days Hours Min.	8. Date of Birth (Month, Day, Yea March 29,19	24 Minnesota
	/land		10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits
	a-f st	ctor	MD Washington_	Boonsbor	ro		1 XYes 2 No
	or 28	Oire	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?
	23a	<b>Funeral Director</b>	141 S. Main Street		21713		USA
	tems	nue	Arr	s Decedent Ever in U.S. 13 ned Forces?	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Evanting ruist be nutfied at ance.	by	If Y	]Yes 2	1 ☐ Yes 2 💆 No Specify:		Specify: White
5	"natu	Completed	15. Decedent's Education (Specify only highest grade comp	leted) 16a. Dec	edent's Usual Occupation re kind of work done during most of work DO NOT use retired)	16b.	Kind of Business/Industry
7	within ene.	ш	Elementary/Secondary (0-12) Co	lege (1-4or 5+)	emaker:		Home
d 2	filed Hygi sther	ပ္မ	17. Father's Name (First, Middle, Last)	TIOIR		e (First, Middle, Maid	
an	ld be lental ked c	To Be	William James Parc	e11	Anna Ma	argaret La	rson
ary	shoul ind M mar	-	19a. Informant's Name/Relationship (Type. Pri		ling Address (Street and Number or Ru		
ž	alth a alth a 27 is		Jeffrey J. Adels / S	on 4878	R Paynes Ford Rd. 1	Kearnevsvi	11e WV 25430
e.	es 1 a of He of He litem		20a. Method of Disposition	cometery cr	B Paynes Ford Rd, I position (Name of penatory or other place)	Date 20c.	Location - City or Town, State
<u>Ĕ</u>	Pages ment of I ant: If ite ury or o'		1 ☐ Burial 2 🙀 Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	I from State	rg Crematorium 10/	16/2010 Sm	ithsburg. MD
Baltimore, Maryland 21	permit. Departi		21. Signature of Funeral Service Licensee	$\supset$	22. Name and Address of Facility Ge	rald N. Mi	nnich Funeral Home
_	20 E 8 9		10 mg		305 N. Potomac St.	C. J	
			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause	s that caused the death. Do not e se on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
A. W.	Physician		Immediate Cause (Final disease or condition resulting in death)	THORACIC	ADRTIC DIS.	وق حيد (٥	
1	/Medical Examiner		resulting in death)	Due to (or as a consequence of):			
	1112 1	ē	Sequentially list conditions, if any, leading to immediate	Oue to (or as a consequence of):			
	uted d ansit	Examiner	Cause (Disease or injury that initiated events				
oʻ	e exection and and and and and and and and and an	Exa		Due to (or as a consequence of):			-
68760,	rificate be executed ng physician and as the burial-transit	Physician/Medical	d				
39 >	ertifica ling pl	Med	IF FEMALE:				*// ===================================
Вох	eath cer attendin for use	ian/	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy		23d. Date of delivery  Month Day Year
P. 0.	uires that the de n signed by the a d be detached fi	ysic		Pregnant at time of death 5 Unknown	Other (specify)		
σ.	that the led by detac		Part II. Other significant conditions contribution	ng to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
rds	n sign	d by	SCLEWTIC CA	IAL INFAR	CTOW ARTER	1 □ Yes	2 No 3 Probably 4 ₩Known
00	w requir s been s should	lete	SCLENOTIC CA	2010 VASEL	LAR DISEASE		24b. Were autopsy findings available
Division of Vital Records,	Attending Physician: The law requires that the death cer redeath.  r defor After.  ector: After this certificate has been signed by the attendir by the funeral director, page 2 should be detached for use.	Completed	WYPERLIPEDEM	A DSTED A	RTHRITIS	autopsy performed 1 ☐ Yes 2 ☐	prior to completion of cause of ? death? 1 □ Yes 2 □ No
<u>ta</u>	ian: rtiflica ctor, p	Be C	25. Was case referred to medical		26. Place of Dea	th (Check only one)	10 10 10 2010
<u>_</u>	hysic nis ce i direc		examiner? 1 ☐ Yes 2 ☐ No Hospita	: 1 ☐ Inpatient 2 ☐ ER/Outpati	ent 3 DOA Other: 4 Nursing H	ome 5 Residence	e 6 ☐ Other (Specify)
0	Attending Physician: The I or death. ector: After this certificate he by the funeral director, page	ü	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	Date of Injury 28b. Time (Month, Day, Year)		28d. Describe how in	njury occurred
si Si	tendl leath. tor: A	cati	2 Accident investigation		M 1 □Yes 2 □No		
<u>\S</u>	or Attendatter deatter Director:	Certification: To	4 Homicide determined	. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, fate)
	pital curs a eral I		29a. Certifier 1 ertifying Physician:	To the best of my knowledge, de-	ath occurred at the time, date and place	and due to the caus	e(s) and manner as stated
	To the Hospital or A within 24 hours after To the Funeral Directorpletely filled in by	Medical	(Check only 2 Medical Examiner: O		investigation, in my opinion, death occu		
	To th withir To th comp	ĕ	29b. Signature and title of certifier		29c. License number		Date signed (Month, Day, Year)
			- act MD		D (8019	00	715,2010
			30. Name and address of person who complete	d cause of death (Item 23a) (Type	e, Print)		
9	5H /+1		DR. VASANT DATTA, 340	MILL STREET, H	AGERSTOWN, MARYLAN	D 21740 3	301-739-7100
	Sta Registr	- 1	31. Date filed (Month, Day, Year)	32. Registrar's Signature	1 41		
Dut	riegisti	ai	OCT 1 5 2010	Dewer A. A			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 06, 2010 Physician/ 1:20 рм Eugene S. Brown Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Marlboro 201 Herrington Drive Prince George If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Days Hours (Month, Day, Year) 2-18-1940 Country) w York Director 69 New 084-34-3473 Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland items 23a or 28a-f sho ner must be notified at Director 1 🔀 Yes 2 🗌 No Upper Marlboro MD Prince George 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral U.S.A. 201 Herrington Drive 20774 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. the Medical Examiner was becedin Even in 0 Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates. 1969 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ō ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: Black "natural", 3 ▼ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working I Hygiene. life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Engineering Electrical Tech permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Swindell Agnes Springette Eugene Brown Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4928 Harford Ave. Beltsville, Maryland 20705 Christopher Brown (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 10-15-2010 Adelphi, Maryland George Washington 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility W.H. Bacon Funeral Home, Inc. Signature of Funeral Service Licensee 3447 14th St. N.W. Washington, DC 20010 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner <u>Atherosclerosis</u> Sequentially list conditions, Il and a cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to jor as a consequence of Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Year Month Day 2 No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 No 3 Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 K No death? 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 💢 No ᅆ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify)

To the Hospital or Attending Physician: The law 'equires that the death certificate be executed within 24 hours after death.

Verthe Funeral Director: After this certificale has been signed by the attending physician and completed filled in by the funeral incertor, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

Manner of Death

Accident

29b. Signature and title of certifie

Andrew J. Lee Jr. 31. Date filed (Month, Day, Year)

5 Pending

Investigation

6 Could not be

determined

13 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12158

1 X Natural

3 Suicide 4 Homicide

29a. Certifier

Certificate:

Medical

Registrar DHMH 17 Rev 7/2009

State

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

injury

28c. Injury at work? 1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

MD

29c. License number

D25647

Central Ave. Mitchellvile, Maryland 20721

X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred

City or Town, State)

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

October 11, 2010

. Date of injury (Month, Day, Year)

W

Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2010 3:25 A M Pancoast Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Hours Min. (Month, Day, Year) ep 29, 1927 1 🔀 M 2 🗆 F Sep Maryland Yrs. Director 217-24-2133 83 Usual Residence of Decedent show 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 ☐ Yes 2X No Maryland Baltimore Ruxton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7830 Chelsea Street 21204 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 X Yes If Yes, Give 2 No 1 Yes 2 XNo Specify: 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. within ? Elementary/Seconday (0-12) College (1-4 or 5+) <u> Architect/Writer</u> Architecture/ Books Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental H ပ be Herbert Pancoast Bangs, Sr Hoffman Margaret permit. Page 1 and 2 st.
Department of Health an.
Important: If item 27 is m. any injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Elizabeth Bangs/wife 7830 Chelsea Street Ruxton, Maryland 21204 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 10/14/2010 Woodbine, Maryland <sup>22</sup> Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L Heckrotte, P.A. Clarksville, MD Signature of Funeral Service Licensee Homas 21029 M00957 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused leach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Éxaminer Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or a consequence of attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Live Birth 2 ☐ Fetal deat
☐ Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No that the death Dav ate has been signed by the page 2 should be detached 9 🗌 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No this certificate 1 Yes Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes Accident
Suicide after death Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital of within 24 hours a To the Funeral D Medical 🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Oertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only or 29b. Signat nd title of

Maryland 21215-0036

Baltimore,

68760

Box

P.0.

Records,

Division of Vital

State Registrar 31. Date filed (Month

DHMH 17 Rev 7/2009

of person who completed cause of death (Item 23a) (Type, Print) 701

Please	Type or	Print	in	Black	Indelible Ink.	Ensure	All	Copies	Are Legible.
	-			—					

			1 _ State	State of Mai	•		t of Health e of Deat		-	0.0	10 00000	
	42		Registrar  1. Decedent's Name (First, Middle, Last)				2. Date of					
h	Physici /Medio		Charles Samuel Boston Jr.				Month 10			09 201		
	Examir		4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death			4c. County of Death		
			32552 Dublin Road,  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)				Princess Anne If Under 1 Year   If Under 24 Hrs.   8, Date			Somerset  of Birth  9. Birthplace (State or Foreign		
	Funeral Director			M 2DE	64 Yrs	Months	Days Hour		(Month, Da	y, Year) 2-1946	Country) Md.	
			Usual Residence of Decedent									
	arylar show	ř	10a. State 10b. County		10c. City, Town or						10d. Inside City Limits 1 ☐ Yes 2 No	
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	Funeral Director	Md. Somerset		Princes	s Anne				10g. Citizen of What		
		I Di	32552 Dublin Road				21853			United	States	
		iner	11. Marital Status	2. Was Decedent Ev Armed Forces?	ver in U.S. 1	3. Was Dece	dent of Hispanic cify Cuban, Mex	Origin? (Spe	ecify Yes or No Rican, etc.)	- 14. Race - A Black, V	American Indian, Vhite, etc.	
36	s after ", or its amine	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give	1163	1 ☐ Yes			,	Specify:	White	
21215-0036	be filed within 72 hour tral Hygiene. Ind other than "natural" event, the Medical Ex	ed b	15. Decedent's Educ	Year or Dates:	1969 16a. De	cedent's Usu	al Occupation			16b. Kind of Busine	ess/Industry	
215		Completed	Flamontony(Secondary (0.12) College (1.4er 5.)							Veri	ZON	
		Соп	12	01		Phon		othir		<b>V</b> -		
Maryland	intai H ed oth	To Be	17. Father's Name (First, Middle, Last)  Charles Samuel Boston, Sr.				18. Mother's Name (First, Middle, Maiden Surname)  Marie Frances Barnes Boston				Boston	
Z	s 1 and 2 should be filed within ? I Health and Mental Hygiene. Item 27 Is marked other than "other traumatic event, the Mec							Number or Rural Route Number, City or Town, State, Zip Code)				
			Rebecca Simpkins	BostonW	ife   325	52 Dub	lin RD.	Princ	ess Ann	ne, Md. 2	1853	
ore	ges 1 ar of He		20a. Method of Disposition  1 ★Burial 2 □ Cremation 3 □ Re	emoval from State	20b. Place of Di cemetery,	sposition (Na crematory or	me of other place)	!	Date	20c. Location - City	or Town, State	
Baltimore,	permit. Pages 1 and Department of Health Important; if Item 27 any injury or other tr once.		4 □ Donation 5 □ Other (Specify)		Beech		emetery	<u> </u>	12-2010	Princ	ess Anne, Md.	
Bal			21. Signature of Funeral Service Licensee  M00295  M00295  M00295  M00295  M00295  Hinman Funeral Home  11673 Somerset Ave. Princess Anne, Md. 21853								Md. 21853	
	Physician /Medical		23a. 11. Enter the disease, or complications, or heart failure. List only on	e cause on each line	١.	_			or respiratory a	rrest,	Approximate Interval Between Onset and Death	
1			Impediate Cause (Final disease or condition resulting in death)  Application of the consequence of the conse									
	Examiner											
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in dealth) Last Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									
	be executed ician and burial-transit	Examiner										
8760,	cate be executed only sician and the burial-transit			Due to (or as a	consequence on.							
9	ificate g physias the	edical	d									
Box	eath certific attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23	3∏Ectonic n	Ectopic pregnancy Other (specify)			23d. Date of delivery  Month Day Year				
	e deat he att		in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown									
P.0	that the de ned by the a								te to the cause of death?			
Records,	requires seen sign hould be	Completed by							1 🗆	Yes 2 <mark>⊈</mark> No 3[	Probably 4 Unknown	
Ö					24a.			Was an 24b. Were autopsy findings available				
E E	sician: The law certificate has b irector, page 2 s	om	autopsy prior to completion of dath?    Description of the completion of the comple							r to completion of cause of th? Yes 2 ☐ No		
Vital	ysician: The is certificate hadirector, page	Be C	25. Was case referred to medical 26. Place of Death (Check only one)									
or/	> .0.0	L <sub>O</sub>	1 Yes & No	ospital: 1 ☐ Inpatien 28a. Date of Injury			OA Other: 4 ⊑ 28c. Injury_at	Nursing Ho		dence 6 Other (	Specify)	
O	Attending r death. ector: After by the funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Inju		Work? 1 ☐ Yes 2	2 □ No	200. Describe	now injury occurred		
Division	Attender death.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injur building, etc.	y - At home, farm (Specify)	, street, factor	y, office		28f. Location (	Street and Number o	or Rural Route Number,	
Ö	ital or irs after ral Dir lled in	Medical Cert								,		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral											
	To t To t		29b. Signature and title of certifier				29c. License number			29d. Date signed (Month, Day, Year)		
	` I		1/aul K Hung	Huz			D24872 ST Pocomoke			10/11/10		
1	1041		30. Name and address of person who co	/ 30	STENT	pe, Print)	- /	OCO	noke	MD 21	85/	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registra	's Signature	1						
	Regist	rar	OCT 13 2	UIV Kens	un B.	gav						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 0749 M Scot David Brockway Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Examiner 4c. County of Death Comia rusl If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days July 23, 1959 Гехаѕ 51 Yrs. 218-20-4680 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director "natural", or items 23a or 28a-f s edical Examiner must be notified Harford Havre de Grace Maryland 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 213 South Union Avenue 21078 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2X No Black, White, etc 1 Never Married 2 Married 1 Yes If Yes, Give þ Baltimore, Maryland 21215-0036 72 hours after White 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 🏿 Divorced Completed Year or Dates and Mental Hygiene.
is marked other than "natur aumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Delivery Driver Self-Employed Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic eveni once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Martha Lou King Allan Reitz Brockway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Park Valley Road, Silver Spring, MD 20910 Martha L. Brockway/Mother 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 D Burial 2 Cremation 3 D Removal from State cemetery, crematory or other place) Crematory of Delmarva 10/11/2010 Delmar, Delaware 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Zeller Funeral Home, P. O. Box 3171 I212 Old Ocean City, Road, Salisbury, of Juneral Service Lic MD 21802 Part 1. Enter the disease, or com shock, or heart failure. List only of plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the cause or each line. Interval Between Immediate Cause (Final Onset and Death C Priysician/ ARS disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed by the attending physician and tached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown page 2 should be detached 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 N certificate 2 🗌 No 1 Tes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes Other: 2 X No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work' 1 Tes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier M. D June Now 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mD

Registrar

Amended #30, 1 per phy., Alle			ase Type or Pr State of M							-		•	le.	
	•	for State Registrar	Otato of It	rai y rai i			te of L		u. 10 111	ornar rij	Reg. N	20	0 33	537
Physiciar Medica		1. Decedent's Name (First, Middle Garnet	Marie		Bily	i				2. Date of D Month	eath	ay O's	3. Time of D	
Examine		4a. Facility Name (if not institution Western MD Regi		l Cen	iter			Location o			4	c. County of D		
Funeral Director		5. Social Security Number 301–16–2116		ge <i>(In yr</i> s. <i>Ia</i> 95	ast birthday) Yrs.	If Und Month	ler 1 Year S Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D 02/04	irth ay, Ye <i>ar)</i> / 191	9. 5 0	Birmplace (State or i Country) hio	Foreign
ind show at	5	Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Loc	cation							10d. Inside City	Limits
Maryla 28a-f s otified	Director	MD All	egany		Cres	apto	own						1 🗆 Yes 2	2 🕅 No
with the is 23a or ust be n	Funeral D	10e. Street and Number 13301 Winches	ster Road, S	W		10f. 2	ip Code	2150	2		10g. C	Citizen of What	Country? USA	
° - 5	≲	11. Marital Status  1 ☐ Never Married 2 ☐ Mar  3 ☒ Widowed 4 ☐ Divorced	If Von Civio					ispanic Orig in, Mexican Specify:		ify Yes or No lican, etc.)	-	14. Race - A Black, W Specify:	merican Indian, hite, etc. White	
5-00	plete	15. Decede	nt's Education est grade completed)		16a. Deced	ent's Us	ual Occup	ation during most	of workin		16b.	Kind of Busine		
2121 within 72 giene. er than , the Me	Completed	Elementary/Seconday (0-12)	College (1-4 or	5+)	life. DO	) NOT u	se retired) emake:	Ü	O WOIKIII	9		Home		
/land d be filed Mental Hy arked oth	To Be	17. Father's Name (First, Middle, I	,	Walto	n				er's Name garei	(First, Middle C	, Maider	surname) Fau	ght	
Baltimore, Maryland 21215-0036 bernit. Page 1 and 2 should be filed within 72 hours after bepartment of Health and Mental Hygiene. mportant: If item 27 is marked other than "natural", only injury or other traumatic event, the Medical Example.		19a. Informant's Name/Relations Ramona Heavner			19b. Mailin 1400	g Addre	ss (Street a Lack	and Numbe Valle	r or Rural y Roa	Route Numb	er, City c , Fl	or Town, State, intsto	Zip Code) ne, MD 21	530
more		20a. Method of Disposition  1  ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (3)		, 0	Place of Disposemetery, crem	atory or	other plac			ate /2010		•	or Town, State	
Balti permit. F Departm Importa any inju		21. Signature of Funeral Service 1		1 1-		Name a	and Addres	ss of Facility	y Ada	ms Fan	nily	Funerand, MD	21502	P.A.
		23a. Part 1. 5 ter the disease, or shock, or heart failure. List of Immediate Cause (Final	only one cause on each lin	е.	h. Do not ente	r the mo			cardiac or	respiratory a	rrest,	_	Approximate Interval Betwee Onset and De	
Physician/ Medical Examiner		disease or condition resulting in death)	Due to (or as	a consequ	ESTIV Jence of): HOR T		ITE	STE		AILU	126			
	aller	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	_		10		2 ( 0 )	- 40	213				
e iai e	al Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	CDue to (or as	a consequ	ience of):									
760 icate be physic	ledic		d											
ivision of Vital Records, P.O. Box 68760 or Attending Physician: The law requires that the death certificate be interdeath.  Director: After this certificate has been signed by the attending physic in by the funeral director, page 2 should be detached for use as the by		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No 9 ☐ Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant a 9  Unknown	2 Teta	I death 3	Ectopio Other (	pregnanc specify)	у				23d. Date of Month	delivery Day Yea	ar
S, P.O.	by P	Part II. Other significant condition	ons contributing to death I	out not resu	ulting in the ur	nderlying	j cause giv	en in Part I					e to the cause of dea	
Division of Vital Records, all or Attending Physician: The law requires is after cleath.  I Director: After this certificate has been signed in by the funeral director, page 2 should be all or the funeral director, page 2 should be all or the funeral director.	oletec									24a. Was	an	24b. Were	Probably 4 Ur autopsy findings ava	ailable
Vital Reco	E										psy ormed? 2 🟋 N	death	to completion of cau i? Yes 2 □ No	ise of
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n of V ding Phys After this funeral di	<u>e</u>	27. Manner of Death	28a. Date of inju	iry	ER/Outpatient 28b. Time of	3 ∐ 1	28c. Injury	4 ∐ Nu rat		ne 5 🗌 Resi 3d. Describe		6 Other (Sp ry occurred	pecify)	
Sion kttendin death. ctor: Aft y the fur	Certificate:	1 X Natural 5 Pendir 2 Accident Investir 3 Suicide 6 Could	gation		injury	М		Yes 2 🗆						
	e	4 Homicide determ	building, et	c. (Specify)	)				7)	City or To	wn, State	e)	Rural Route Number	
the Hospital hin 24 hours the Funeral Tipleted filled	Medical	(Check 2 Medical E	Physician: To the best of ixaminer: On the basis of e Nurse Practioner: To the	xamination	and/or investi	gation, in	my opinio	n, death occ	curred at the	he time, date	and place	e, and due to the	ne cause(s) and mann	er stated.
To the company	— г	29b. Signature and title of certifier		7.0			c. License	number			29d. Da	ate signed (Mo	nth, Day, Year)	
4	-	30, Name and address of person	10/11/10	looth ///	020) 75: 5	dimt\ NI	-	6416			ι	0/11	10	
nos		600 Memor	_		1MBE				n1, Μ. <u>(\)</u>	21	202			
State Registrar		31. Date filed (Month, Day, Year)	32. Registr	ar's Signati	ure /	1			,					

10-07641 Elmer Beckley Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 33538 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 5, 2010 0405 hrs Medical Examiner Elmer Harsh Beckley 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Washington Washington County Hospital Hagerstown 9. Birthplace (State or Foreign Maryland Country) 8. Date of Birth (MM/DD/YYYY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Hours Director 217-40-1251 1XM 2 F 69 Dec. 5,1940 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Y Yes 2 No Maryland Washington County 23a or 28a-f show notified at once. Hagerstown permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 S. Mont Valla Ave. 21740 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married 1X Yes If Yes, Give Year 1958-1964 1 Yes 2 No specify: 4 Divorced Specify: White \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) narked other than event, the Medical 12 Mason Tender Masonry Company 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Walter Beckley Pearl Harsh Becklev 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis H. Beckley-wife 200 S. Mont Valla Ave. Hagerstown, <u>MD 21740</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Cedar Lawn Mem. Park 10-9-2010 Hagerstown, Maryland 4 Donation 5 Other Specify 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown 23a. Part I. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hea Physician Between Onset and /Madical Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and or use as the burial - tran-Physician/Medical UNPENDED **AMENDED** Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death Ectopic pregnancy Live birth past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown Unknown 23e, Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o \$ 1 Yes 2 No 3 Probably 4 V Unknown σ. npleted Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed' Com Yes 2 ✔ No 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be examiner? Other Nursing Home 5 Residence 6 Other this 1 V Yes ဥ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d, Describe how injury occurred 1 V Natural 1 Yes 2 No 5 Pending 2 \_\_\_ Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 241 Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. COME October 5, 2010 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Theodore M. King, Jr., MD. NOH 4+1 State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October <sup>□</sup>9, 20°10 David Wen-Wei Chang 9:20 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Bedford Court Nursing Home Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ Months Davs Hours Min. July I, 1929 China Director 408-56-9510 81 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a State 10b. County 10c, City, Town or Location 10d Inside City Limits Director Montgomery Maryland Silver Spring 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3520 Tarkington Lane 20906 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. 6 Battimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after 1 beş artment of Health and Mental Hygiene. Deş artment of Health and Mantal Hygiene important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir <u>\$</u> 1 Never Married 2X Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced Asian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) University Professor Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Yin Chang Jing-Shuang Wei 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3520 Tarkington Lane Silver Spring, MD 20906 Alice G. Chang/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 10/12/10 4 Donation 5 Other (Specify) Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home 500 University Blvd. West, Silver Spring, MD 20901 Part 1. Enter the disease, or complications that cau he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, if heart failure. List only one cause on each line. 23a, Part 1 Interval Between Onset and Death Immediate Cause (Final Physician/ Bladder Carcinoma disease or conditi-resulting in death) Medical Due to (or as a consequence of) Examiner Pulmonary Embolism Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit that the death certificate be executed Cause (Disease or linjury Hypertension that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Vear Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔯 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2X No death? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physiciam: within 24 hours after death.

To the Funeral Director, After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Yes 2 X No 잂 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

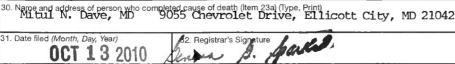
Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Box 68760 P.0. Records, Division of Vital

Registrar

31. Date filed (Month, Day, Year, OCT 13 2010

29b. Signature and title of certifier



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29c. License numb

29d. Date signed (Month. Day Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State o	f Maryla		artment of H		and M	ental Hy	giene	10	33540
			Registrar  1. Decedent's Name (First, Middle,	/ oot)		Cer	tificate of L	Death			Reg. No.	110	33340
	Physicia	ın/		,		_				<ol><li>Date of Dea Month</li></ol>	Day	Year	3. Time of Death
	Medic		Hugh Granv  4a. Facility Name (if not institution)		lston,	Jr.	45 Ott. Town or			<u>Octobe</u>	r 8, 20		3:05 P <sup>M</sup>
	Examir	ler	Holy Cross Hos		Delj		4b. City, Town, or	ver Sp			4c. Coun	ty of Death	romow z
	Funeral			S. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 2		8. Date of Birt	h	Monto	place (State or Foreign
	Director		212-80-7532	1 1 1 M 2 □ F	51	Yrs.	Months Days	Hours	Min.	oct 9,	1958	Court	chigan
	d tow	L	Usual Residence of Decedent  10a. State 10b. County		10-0	. T							
	arylar a-fsh fied	cto	,		100.0	ity, Town or Loc							0d. Inside City Limits
	or 28	Ë	DC 10e. Street and Number			Washin	10f. Zip Code				10g, Citizen o	( ) A ( ) - ( ) - ( )	1 Yes 2 No
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho t, the Medical Examiner must be notified at	<b>Funeral Director</b>	1711 Massachus	etts Aven	ue. NW	#708	200	36					States
	leath items er mu	Fun	11. Marital Status	12. Was Dece	dent Ever in U.	.S. 13. V	Vas Decedent of Hi	spanic Orig	in? (Spec	ify Yes or No-		ace - Americ	
98	fter d ", or i amin	Š	1 Never Married 2 🔀 Marrie	Armed For 1  Yes If Yes, Give	2 🔀 No		Yes, specify Cuba		Puerto R	ican, etc.)	Bla	ack, White,	
Ö	ours a	Completed	3 Widowed 4 Divorced	Year or Da			☐ Yes 2 ☐xNo	Specify:			Specia	<sup>fy:</sup> Wh	ite
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Maryland	9 5 9 0	스	Hugh Granvi	lle Cols	ton, Si	r.		Pat	rici	a Ann	McCair	1	
lar	should by and Me	C 00	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Street a	and Number	or Rural	Route Number	; City or Town,	State, Zip C	Code)
	and 2 Health tem 27		Dana Lynn Thoma	as/wife_				setts	Ave,	NW #7	08 Wash	ningto	n, DC 20036
altimore,	ge 1 and nt of Hea : If item or other		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3	Removal from		Place of Dispos cemetery, crem	sition (Name of natory or other place	e)	Da	ite	20c. Location	- City or To	wn, State
ቜ	it. Page rtment o rtant; If njury or		4 Donation 5 Other (Sp				ney Crema						Maryland
Ba	permit. Page 1 Department of Important; If it any injury or o		21. Sign Kire of Funeral Service Liquida	Homas	MOO	Gö 0957 Be	Name and Addres ing Home verly L.	s of Facility Crema Heckr	tion	Servi P.A.	ce P.O. Clarks	Box ville	784 , MD 21029
			23a. Part 1 Enter the disease, or conshock, or heart failure. List on	omplications that ca y one cause on eac	aused the deat	th. Do not ente	r the mode of dying	g, such as c	ardiac or	respiratory arm	est,		Approximate Interval Between
-	Physiciani		Immediate Cause (Final disease or condition	Panc	reatic	Cancer							Onset and Death
	Medical Examiner		resulting in death)		r as a conseq								
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л Э	hat th ed by detac	된	Part II. Other significant conditions	contributing to dea	ath but not res	sulting in the un	derlying cause give	en in Part I.		23e. Did to	nacco use con	tribute to th	e cause of death?
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VISION OF	ing P		27. Manner of Death  1 Natural 5 Pending	28a. Date of (Month	injury , <i>Day, Year)</i>	28b. Time of injury	28c. Injury work?	at			w injury occur		
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Š	lor A after Direc	ا ق	4 ☐ Homicide determine	d 28e. Place o building	f Injury - At ho g, etc. (Spec <i>if</i> y	me, farm, stree ')	et, factory, office		28	f. Location (St City or Town	reet and Numb , State)	er or Rural i	Route Number,
ב	spital spital neral i filled	g	29a. Certifier 1 Certifying P	nysician: To the bes	st of my knowl	ledge death or	cured at the time	date and nis	ace and	tue to the cau	se(s) and mann	or as stated	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Exa only one) 3 Certifying N	miner: On the basis	of examination	n and/or investig	ation, in my opinior	death occu	irred at th	e time date an	diplace, and du	e to the caus	se(s) and manner stated
	Vithi Vithi Com		29b. Signature and title of certifier				29c, License		, , , , , , , , , , , , , , , , , , ,		9d. Date signe		
			Barbare Su	panich.	RSM A	ND	Doa	5483	)		10/8	120	10
	4		30. Name and address of person wh	completed cause	of death (Item	23a) (Type, Pri	nt)						
			Barbara Supanic	n, RSM, M	.D. 15	00 Fore	st Glen I	Road	Silv	er Spr	ing, Ma	rylan	d 20910
	State Registra		OCT 13	2010 32.	istrar's Signat	d. Asa	aked						

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		Registrar  1. Decedent's Name	/First Middle	I act)			Certifi	icate of L	<i>Death</i>		2. Date of De	Reg. No	<u>.20</u>	0	<u> 335</u>	44
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Medic , Examin		4a. Facility Name (if	not institution,	give street and num	ber)			o. City, Town, o	r Location	of Death	00 100	- 1	. County of			
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Funeral Director		5. Social Security No		6. Sex 1 □ <b>x</b> M 2 □ F	7. Age (/ 6	n yrs. last birth O		onths Days	Hours Hours	Min.	8. Date of Bi (Month, Date 25	rth ay, Year) <b>10</b>	40	Birthp Count Mars	lace (State or F ry) Land	Foreign
		214-38-13 Usual Residence of	Decedent						L		Dec 25		770			
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fur	neral Service Lie	ensec				ame and Addre ng Home verly L								
₫ <b>□ ⊑ ii ii</b>		23a. Part 1 Enter t	nita (+	Thomas		M00957							arksv	$\frac{\mathrm{ill}\epsilon}{ }$		1029
Physician/		shock, or hear	t failure. List on	ly one cause on ea	ch line.										Approximate Interval Betwee Onset and De	
Medical		disease or condition resulting in death)	n 🔏	Due to (	or as a c	onsequence o	):	RUCTI	ve_	TVLI	NOWHE	y D	15PAS	e	YEAK	25
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e Hos 124 ho e Fune leted f	Medical	(Check 2	■ Medical Ex	Physician: To the be aminer: On the bas Nurse Practioner: 1	is of exar	nination and/or	investigat	tion, in my opinio	on, death	occurred at	the time, date	and place	e, and due to	the cau	se(s) and mann	ner stated.
To the To the Comp	~	29b. Signature and		111	1	/ /		29c. License	e number	-		29d. Da	ate signed (A	Aonth, E	Day, Year)	
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14		30. Name and addre	ess of person w	ho completed caus	e of deat	h (Item 23a) (T	ype, Print)	241/	ani -	C	Ba	unn.	· M	0	2120	94
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Registra	ar		UU 13	ZUIU AX	CHERRA	U B.	1000	New								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 20ÏÖ 4:45 а м Marjorie Windsor Creighton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Dorchester Chesapeake Woods Center Cambridge 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Dec. 25, 1919 Director 214-07-9705 90 Maryland Usual Residence of Decedent items 23a or 28a-f show 10a. State 10b. County other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Completed by Funeral Director MD Dorchester Cambridge 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4744 Bucktown Road 21613 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. ō 1 Never Married 2 Married ☐ Yes 2 🕱 No Baltimore, Maryland 21215-0036 white If Yes Give 1 Yes 2 X No Specify: "natural", 3 XWidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event; the Mea once. Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last)
James T. Windsor 18. Mother's Name (First, Middle, Maiden Surname)

Trene Willey ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert H. Creighton Jr. son 4862 Rhodesdale Vienna Rd., Vienna, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State East New Market Cem. 10/10/10 East New Market, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Rome P.A. Funeral Service Nicensee 700 Locust St., Cambridge, MD Sold 23a. Part 1/£nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph sician/ dementia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner levoscerotic vascular disease Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use as the burial Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year 1 ☐ Yes ≥ 1 9 ☐ Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate h perform 1 Yes 2 No 2 X funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) 10 8/10

DHMH 17 Rev 7/2009

State Registr<u>ar</u> 100 Bramble

32. Registrar's Signature

Cambridge MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene 33543 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ay 2010 ear OCTOBER MICHAEL DENNIS COURSEY 6:05  $\mathbf{P}^{\mathsf{M}}$ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **OUEEN ANNE'S OUEENSTOWN** 200 OLDE POINT LANE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, AUG. 15 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 🕱 M 2 🗆 F Director 60 219-60-2040 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City. Town or Location 10d. Inside City Limits Director **OUEEN ANNE'S** QUEENSTOWN 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 200 OLDE POINT LANE 21658 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces' 1 Never Married 2 😾 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced Year or Dates.1971-1976 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) ARCHITECTURE DRAFTSMAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 ISABEL HOXTER WILLIAM RAY COURSEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 OLDE POINT LANE, QUEENSTOWN, MD 21658 LINDA DALE COURSEY/ WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State OCT. 12, CENTREVILLE, MD CHESTERFIELD CEMETERY 4 Donation 5 Other (Specify) 2010 21. Signal Faneral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition resulting in death) cance STOMAN Medical Due to (or as a consequence of): Examine Sequentially list conditions Examine it day, leading to immedit cause. Enter Underlying Cause (Disease or linjury Directo for as a nonsequence of the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ Unknown 9 Unknown signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been signector, page 2 should f 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 1 Yes 2 No 유 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 X Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injurv 5 Pending Accident Investigation 24 hours after death Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the only one 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year, 10

State Registrar 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Day, Year)

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Year DERO 0400 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4113 Offut Dr. Suitland Prince George's 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min New York Director 096-20-0733 82 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 ☐ Yes 2xx No Prince George's Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4113 Offut Drive 20746 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married 1946 1XX Yes 2 □ No If Yes, Give Year or Dates Specify: Puerto Rican Specify: 3 Divorced 4 Divorced Completed 47 White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Federal Aviation Admin Elementary/Seconday (0-12) Sollege (1-4 or 5+) Electronics Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Cordero , Sr. Agripina Ramos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4113 Offut Drive Suitland, Maryland Helen Cordero / Wife 20746 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/16/2010 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cem. Clinton, Maryland 21. Signature Funeral Sep de Licer 22. Name and Address of Facili@eorge P. Kalas Funeral Home PA 6160 Oxon HI11 Rd. Oxon Hi11. Maryland 20745 23a. Para / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Priysician nonths disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death been signed by the a should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 Yes 2 No Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 🗌 No 1 🗌 Yes 2 Z N Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Tes 2 📝 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🖊 Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation Accident after deatl ☐ Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier within 24 hor

To the Fune

completed fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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LAPE MICHAEL 445 DEFENSE MD J NTA 31. Date filed (Month, Day, Year) 32. Registrar's Signature OCT 1 3 2010

30. Name and address of pron who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

State

Registrar

11:2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend#17perfuneral home10/13/2010ccdehrb State
Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Menth 10 Pay 20 10 4:04 AM Betty June Clark Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George's Clinton Southern Maryland Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Country) WV 1 🗆 M 2 🔀 F Months Days Hours Director 227 54 5268 68 1/01/1942 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George' Brandywine 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 10505 Cedarville Rd.Lot 10-14 20613 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian Armed Forces?

1 Yes 2 KNo If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ð 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sasmi Trust Fund 11th <u>Manager</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Jesse Everett Fowler Everett Fowler Muriel Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20613 Henry M.Clark/ Husband 10505 Cedarville Rd.Lot10-14Brandywine,MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State |10/15/201| Beltsville,MD 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. 22. Name and Address of Facility Briscoe-Tonic Funeral Home 21. Signature of Funeral Service License 294 Old Washington Rd. Waldorf, MD 20601 se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part 1. Enter the diseas shock, or heart failure. Approximate Interval Between Onset and Death M 50 C1- d. 1501 we Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Due to (or se a consequence or, Examin Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 3 Ectopic pregnancy 5 Other (specify) Year Month Dav Pregnant at time of death 1 Yes 2 the cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 XN eral Director: After this certificate filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 → No 잍 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after To the Funeral Direct Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check з 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 0111110 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month bec M A06.14 Janet Delores Carty 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Washington Washington County Hospital Hagerstown 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2**X** F Hours MinSeptember 4,1934 Maryland 76 215-42-4150 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 🗌 Yes 2 🗓 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 10825 Oak Valley Drive 21740 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married 1 Yes 2 X No 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul Derr Kershner Helen Mav Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 56 Regal Drive, Falling Waters, W. VA. 25419 Debra K. Drewry Daughter In Law 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Donation 5 Dother (Specify) Entombment Cedar Lawn Mem. Pk. 10-18-10 Hagerstown, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Andrew K. Coffman Funeral Home, Inc. Troel 40 East Antietam Street, Hagerstown, 23a. Part 1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) (or as a cons Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Year Day Month Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1. Yes 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 2 No 1 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)

Pnysician/ Medical **Examiner** 

Physician/

Medical

Director

Funeral

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**Examiner** 

**Funeral** 

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

the Medical

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permit. Page 1 and 2 should be filed within 72
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "I any injury or other traumatic event, the Medica.

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examine the burial-transit and artending physician Physician/Medical as sate has been signed by the artending page 2 should be detached for use þ Completed certificate Be ျပ After this Certificate:

the Hospital or Attending Physician: The law requires that the dea h cerificate be executed Division of Vital Records, P.O. Box 68760 completed filled in by the funeral director, 24 hours after death.

Funeral Director; A

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State Registrar

within 2

Medical

Carried	1/16	1.		_		
1.1	Date filed	(Month,	Day,	Year)		
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30. Name and address of person who cor

29b. Signature and title of certifier

27. Manner of Death

1 Natural

Accident Suicide

4 Homicide

29a. Certifier

5 Pending

Investigation

determined

6 Could not be

	0		Mi
leted cause of deat	h (Ite	m 23a)	(Type, Pri

28a. Date of injury

(Month, Day, Year)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

28c. Injury at work? 1 ☐ Yes 2 ☐ No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number,

28d. Describe how injury occurred

City or Town, State)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

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	, p, s		for State Registrar	State of	Maryland / D		tificate of E		and iv	_	giene Reg. No.20	10	33547
	Physicia Medi		1. Decedent's Name (First, Midd Ronald L. Dames				-			2. Date of De Montocto	ath ober 13, 201	0 <sup>Year</sup>	3. Time of Death 01:00 PM <sub>M</sub>
	Exami		4a. Facility Name (if not institution 20000 Old Midloth				4b. City, Town, or	Location of Midlo			4c. County Allega	of Death	
	Funeral Director		5. Social Security Number 215-36-8513	6. Sex 1 A M 2 A F	Age (In yrs. last birth	day) ′rs.	If Under 1 Year Months Days	If Under: Hours	24 Hrs. Min.	8. Date of Bird	t 10,71939		lace (State or Foreign Fland
	yland f show ed at	tor	Usual Residence of Decedent  10a. State  10b. Count	•	10c. City, Town		ation					10	Od. Inside City Limits
	he Mar or 28a- e notifie	Director		legany 00 Old Midlothia	Midloth	uan	10f. Zip Code				10g. Citizen of	Mhat Count	1 X Yes 2 No
	h with the same same same same same same same sam	Funeral		Box 374			21543-				U.S.A.	Wild Count	
9800	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	<u>ک</u>	11. Marital Status 1 □ Never Married 2 ☑ Ma 3 □ Widowed 4 □ Divorce	d If Yes, Give Year or Dates	No	lf	as Decedent of His Yes, specify Cubar  ☐ Yes 2 M No	n, Mexican	in? (Spec , Puerto F	cify Yes or No- Rican, etc.)	Blac	e - America ck, White, e Whit	tc.
21215-0036	within 72 hor giene. er than "nat i, the Medica	Completed		ent's Education lest grade completed)  3 College (1-4	or 5.1)	Give ki ife. DO	ent's Usual Occupa ind of work done do NOT use retired) ary/Treasure	uring most	of workin	g	16b. Kind of B		Commissi on
Maryland	ld be filed Mental Hy larked oth atic event	To Be	17. Father's Name (First, Middle, Woodrow W. Dar						r's Name e <b>l Dud</b>		Maiden Surname	e)	
, Mar	nd 2 shou ealth and m 27 is m	1	19a. Informant's Name/Relations  Mary Damewood				Address (Street a Id Midlothian			Route Number lothian	; City or Town, S <b>Mary</b>		21543-
Baltimore,	t. Page tment c rtant: If rjury or		20a. Method of Disposition  1 🔀 Burial 2 🗌 Cremation 4 🔲 Donation 5 🗍 Other (	Specify)	ate 20b. Place of I cemetery Frostb	Disposi crema urg N	ition (Name of atory or other place <b>Memorial Parl</b>	ž		ate er 16, 2010	20c. Location - Frostburg	-	vn, State I <b>aryland</b>
Bal	Depar Impo		21. Signature of Funeral Service	2. Wurd	1	22.	Name and Address Durst Funera	s of Facility al Hom	e, 57 F	rost Ave.	Frostburg	, MD 2	1532
	Ph sician/ Medical Examiner	ıer	23a. P. 1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. Due to (or a	line.	:					est, MOI		Approximate Interval Between Onset and Death
092	icate be executed physician and s the burial-transit	ledical Examin	cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	c	as a consequence of)								
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. Within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burn of the page of t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes - 2 No 9 ☐ Unknown		th 2 Fetal death		Ectopic pregnancy Other (specify)				, 23d. Dat Mo	e of deliver	y Day Year
ls, P.O.	uires that the signed by all the detail	by	Part II. Other significant conditi	ons contributing to deat	h but not resulting in	the und	derlying cause give	en in Part I.					cause of death?
Division of Vital Records,	The law req	Completed			-					24a. Was a autop perfor	med? c		sy findings available pletion of cause of
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vision	or <b>Attendi</b> fter death. irector: A r by the fu	Certificate:	2 Accident Investi 3 Suicide 6 Could 4 Homicide determ	gation not be 28e. Place of I	Injury - At home, farm	ı, stree	M 1 □ Y	es 2 □ 1	-	8f. Location (Si	reet and Numbe	r or Rural R	Poute Number,
۵	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completed filled in by the funeral director.	Medical C	29a. Certifier 1 Certifying (Check 2 Medical I	Physician: To the best Examiner: On the basis o	of my knowledge, de	ath occ	cured at the time, o	date and pl	ace, and	due to the cau	se(s) and manne	er as stated.	a(c) and manner stated
	To the I within 2 To the I complet		only one) 3 Certifying 29b. Signature and title of certifie	Nurse Practioner: lot	he best of my knowled	lge, de	ath occurred at the	time, date a	and place,	and due to the	cause(s) and ma 29d. Date signed	nner as stat	ed.
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	nus		30. Nar <b>At appA</b> ddress of person Alida Podr	umar, 125	00 Willo	wb	rook Rd	, SE	, Cı	umberl	and, M	D 21	501-0539
	Stat Registra	e ir	31. Date filed (Month, Day, Year)	0 2 32. Regis	strar's Signature	Care de	,						

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month October 2010 4:30 A Dagenhart Gerald Lee 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Julia Manor Health Care Center Hagerstown 5. Social Security Number If Under 1 Year Jf Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 1 X M 2 □ F Hours Mary Land 80 220-26-2461 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Sharpsburg Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21782 102 South Hall Street Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Automobile 9 Lot Attendant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Catherine Warrenfeltz Lawson Dagenhart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21782 102 South Hall Street Sharpsburg, Maryland V. Bernice Dagenhart / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 20c. Location - City or Town, State Donation 5 Other (Specify) Mountain View Cemeter 10/16/2010 Sharpsburg, Maryland 21. Six ture of the lose lice Licens e 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA

Physician/ Medical Examiner

5 any injury

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10a. State

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**Examiner** 

**Funeral** 

Director

or 28a-f show

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho

Baltimore, Maryland 21215-0036

item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at

attending physician and for use as the burial-trans

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

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cal Examiner	23a. Pary 1. Enter the disease, or complic spock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	nsi:	ratory F	alure		Approximate Interval Between Onset and Death
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  Part II. Other significant conditions cont	4 Pregnant at time of death 9 Unknown	3	pecify)	23e. Did tobaco	23d. Date of de Month	Day Year
ed by					1 ☐ Yes	2 □ No 3 □ F	Probably 4 Unknown
Complete	Benya	frostale 14	ype	trophy	24a. Was an autopsy performed' 1 \sum Yes 2	prior to death?	utopsy findings available completion of cause of
Be	25. Was case referred to medical			26. Place of Death (Che	ck only one)		
일	examiner? 1  Yes 2 No	ospital: 1 🔲 Inpatient 2 🗆 ER/Outpa	atient 3 🗌 De	OA Other: 4 Nursing H	ome 5 Residence	6 Other (Spec	cify)
ficate:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Tim inju		28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
edical Certificate:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	, street, factory	y, office	28f. Location (Street City or Town, Sta		ıral Route Number,
<b>Nedica</b>	(Check 2 Medical Examine	ian: To the best of my knowledge, dea er: On the basis of examination and/or in Practioner: To the best of my knowled	nvestigation, in	my opinion, death occurred	at the time, date and pla	ice, and due to the	cause(s) and manner stated

29c. License number

29d. Date signed (Month, Day, Year)

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State Registrar

WH-2

within 24 hours after death.

To the Funeral Director: Air completed filled in by the fu

29b. Signature and title of certifier

he mi e and address of person who completed cause of death (Item 23a) (Type, Print)

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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended ited State Registrar#8, perF. Home, 10/12/10, BA Certificate of Death WCHD 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1 1 ay Physician/ Month OCt. 2010 7:05 a<sup>M</sup> James Lawrence Dooling, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Worcester Pocomoke City Hartley Hall Nursing Home If Under 1 Year If Under 24 Hrs Age (In yrs. last birthday) 8. Date of Birth 1920 9. Birthplace (State or Foreign **Funeral** 1020 New Jersey 1 🛛 M 2 🗆 F Days Hours (Month, Day Director 90 153-07-9455 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🏿 Yes 2 🗆 No Pocomoke City MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1006 Market Street 21851 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Bace - American Indian. 11. Marital Status rmed Forces? Yes 2 \( \sum \) No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White If Yes, Give WWII 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Grocery Store Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Clara Wolpert James Lawrence Dooling 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 31867 Rehobeth Road, Pocomoke City, MD 21851 Joy Long (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Mary Scenetery 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/14/2010 Pocomoke City, MD eture of Functial Service Licenses 22. Name and Address of Facility Home, Professional Association 107 Viné Street, Pocomoke City, MD 21851 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death Yes 4 ☐ Pregnam 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use continute to the cause of death?

Hospital or Attending Physician: The law requires that the death certificate be executed s been signed by the attending physician and should be detached for use as the burial-tran After this certificate has been funeral director, page 2 should s after death

Completed

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Certificate:

29b. Signatur

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1.XNatural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 1 Fertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one

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D 31. Date filed (Month, Day,

feelnd title of certifie

Name and address of person

CTEM

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Terasa LaJoyce		ITS State Registrar	State of Maryla		ment of <i>icate of</i>		Mental H		201	0 33550
Physicia Medical Exami	an/	Decedent's Name (First, Mid TERAS		E EVANS				2. Date of Deal Month October 6	th Day Year	3. Time of Death 0858 hrs
		4a. Facility Name (if not institut 2500 Markham Lane	tion, give street and nu	ımber)	4	b. City, Town, or L Landover	ocation of Death		4c. County of E Prince Geo	
Funeral Director		5. Social Security Number 260-33-8750	6. Sex	7. Age (In yrs. last b	birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hrs Hours Min.		}   F	). Birthplace (State or or oreign Country GEORGIA
Maryland 28a-f show any d at once.		Usual Residence of Decedent  10a. State 10b. County  MD • PRIN	y CE GEORGES	10c. City, Tov		on HELLVILL				10d. Inside City Limits 1 X Yes 2 No
he Marylan or 28a-f sl	Director	10e. Street and Number		<u>'</u>	MIIO	10f. Zip Code		10	Og. Citizen of What	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2		2 X No	lf Y€	s Decedent of Hisp es, specify Cuban, Yes 2 X No	eanic Origin? ( Sp Mexican, Puerto		- 14. Race - A White, e	merican Indian, Black,
21215-0036 uld be filed within 72 hours after de Mental Hygiene. marked other than "natural", or event, the Medical Examiner m.	Completed by	15. Decedent's Education (Sp Elementary/Secondary (0-12	pecify only highest gra-	de completed) 16	a. Decedent during mo	's Usual Occupationst of working life. I	on (Give kind of v		16b. Kind of 8usin	ess/Industry
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medica	Be	17. Father's Name (First, Middl	e, Last)	EVANS		18		FELICIA	Maiden Surname)	ELL
MD 2 rd 2 shoul alth and M m 27 is m aumatic	٩	19a. Informant's Name/Relation FELICIA CARS 20a. Method of Disposition	WELL/MOTHE	cr 1	1803	JESTER C	r., MITC	HELLVIL	LE, MD. 2	0721
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		1 Burial 2 X Crematic		om State crem	natory or oth	tion (Name of cemo er place) CREMATORY		Date 12-2010	20c. Location - Cit	
Balti permit. Departm Imports injury o		21. Signature of Funeral Service	e Licensee	D M0009	<sup>22</sup> CH 1 58	AMBERS FU	reaciity UNERAL H LAND AVE	OME & C	REMATORIU RDALE, MI	M,P.A.
Physician Madical Examiner		23a. Part I. Enter the disease, of failure. List only one caus Immediate Cause (Final diseas or condition resulting in death)	se on each line. se a. <mark>Gunshot W</mark>	aused the death. Do founds (2) of He consequence of):			uch as cardiac o	r respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	C	consequence of):						
50, te be executed ysician and burial - transit	al Exa	events resulting in death) Last	Due to (or as a	consequence of):	5 -01/	/ 15 11				
760, cate be ex physician he burial	Medical	IF FEMALE:	23c. If yes,	8 per inf		4-15-11			23d. Date of del	ivery
D.O. Box 6876( that the death certificate ned by the attending phy detached for use as the b	Physician/M	23b. Was decedent pregnant in past 12 months?  1  Yes 2 No 9 ✓ Ur	4 Pregn	ant at time of death	- 1	aldeath 3 er (Specify)	_Ectopic pregna	ncy	Month	Day Year
P.O. res that the signed by be detach	ā	Part II. Other significant cond	litions contributing to	death but not result	ting in the ur	nderlying cause giv	ven in Part I.			e to the cause of death?  Probably 4 Unknown
Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the l	Completed							24a. Was a autops perform 1 🗸 Yes 2	sy prior m <u>ed</u> ? deat	e autopsy findings available to completion of cause of h? Yes 2 No
Vital hysician: this certif	o Be	25. Was case referred to medic examiner?  1 ✓ Yes 2 No	Village State	npatient 2 ER/	/Outpatient		of Death (Check of other: 4 Nursing		Residence 6 🗸 C	Other: Scene
Division of Vipital or Attending Physions after death.  reral Director: After this filled in by the funeral di	ation: T		estigation Oct 6, 2	Day,Year) FC	o. Time of In DUND: 36 hrs	1 Ye	es 2 🗸 No	Subject shot		
Division  To the Hospital or Attend within 24 hours after death. To the Funeral Director:	Certification	4 V Homicide det	ermined (Specify)	e of Injury - At home, Parking Lot				or Town, St 2500 Markhan	ate) n Lane , Landove	
D To the Hospital within 24 hours To the Funeral Completely filled	Medical	(Check only one) 2 Medical Ex	Physician: To the bes aminer: On the basis of and manner_s	of examination and/o						
3	ğ	29b Signature and title of certif	mico	- Poll	el on	29c. License O.C.M			29d. Date signed October 7, 20	
		<ol> <li>Name and address of perso Patricia Aronica-Polla</li> </ol>		e of death (Item 23a ant Medical Exa		111 Penn Stre	eet, Baltimore	e, MD 21201		
St Regist	ate	31. Date filed (МП Дау, Теа́г	3 2010 32	gistrar's Signature	Jan	Ked				

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2010 Physician/ October 12, Amy Clarke Ellis 2:50 a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In vrs. last birthdav) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. April 4, 1910 1 □ M 2 🕱 F 554-76-7187 1.00 MΆ Director Yrs Usual Residence of Decedent with the Maryland ian "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 28a-f sho 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Montgomery Be the sda 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 4920 Sentinel Drive, Apt. 204 20816 TISA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 hours after Specify: White 1 ☐ Yes 2 ☐ No Specify: Completed 3 √ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) 72 (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Poet Literary other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of Charles E. Clarke Addie Byam other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Clarke N. Ellis/Son 4920 Sentinel Drive, Apt. 204, Bethesda, MD 20816 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖺 Burial 2 🗌 Cremation 3 🕱 Removal from State Oct. 19, Fort Rosecrans Nat'1 San Diego, CA 4 ☐ Donation 5 ☐ Other (Specify) 2010 Cemetery 21. Signature of Funeral Service Name and Address of Facility CCIS J. COllins Funeral Home Inc. MO1606 500 University Blvd. W., Silver Spring, MD 20901 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-to-nsit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or ii that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 9 Unknown g Unknown Division of Vital Records, P.O. signed by t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been signated by page 2 should b 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? After this certificate 2x No Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 \sum Yes 2 \sum No Other: ျှ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 2 🗌 No Accident Suicide Investigation within 24 hours after death

To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D65720 October 12, 2010

Registrar
DHMH 17 Rev 7/2009

State

Rosemary Iwunze, MD

3

31. Date filed (Month, Day, Year)

OCT

G

Bethesda, MD 20814

completed cause of death (Item 23a) (Type, Print)

ID 8600 Old George town Road,

. Registrar's S<del>ig</del>

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 10, 2010 Sharon Elaine Evans 17:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Community Hospital Cheverly Prince Georges Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗗 F 523-72-9986 Hours Aug. 13, Year 1951 59 Pueblo, Co. **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince Georges 1 ¥ Yes 2 ☐ No Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2304 Brightseat Rd. Tl 20785 United States . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? 10' Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify:Black 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Special Police Ofc. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Chester Mitchell Lala Ema Meatas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele Javins / Daughter 4235 N. Shore Dr. Prince Frederick, Md. Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Metropolitan 1 Burial 2 Cremation 3 Removal from State Name and Address of Facility 10/14/2010 Alexandria, Va. 4 Donation 5 Other (Specify 21. Signature of Funeral Service Lice 20747 Approximate Interval Betw 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Examir Hospital or Attending Physician: The law requires that the death certificate be executed and for use as the burial-trai that initiated events Due to (or as a consequence resulting in death) Last ned by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be o 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be 2 Hospital Other: ၉ 1 Tes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Man fer of De th Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? Natural 5 Pending Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. filled in by 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of pertifier 29d. Date signed (A onth, Day, 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Demetrios James Catevenis, M.D. 3001 Hospital Dr. Cheverly, Md. 20785

DHMH 17 Rev 7/2009

State Registrar Date filed (Month, Day, Year) 0CT 1 3 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Elisa Lenore Edwards Certificate of Death 1- For State Rea. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day October 7, 2010 0610 hrs Edwards Medical Examiner Elisa Leanore 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's 5715 Plata Street Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex **Funeral** Foreign Country Hawaii Months Hours 10/23/1952 57 Director 576-58-3788 1 M XX F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location ij 10a, State 1 Yes 2 X No 28a-f show Marvland Prince George's Clinton Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at nace. rector 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20735 5715 Plata Street 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. Funeral If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 X X Married 2 X No Yes Specify: Filipino 1 Yes 2X X No specify: 3 Widowed 4 Divorced ð 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n injury or other traumatic event, the Medical E. U.S. Postal Service 2 vears Administrative Coordinator 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Teresa 0baldo 0bra Rosendo Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 5715 Plata Street Clinton, Maryland Catherine V. Edwards / Daughter 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 10/16/2010 Edgewater, MD Kalas Crematory Donation 5 Other Specify: 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 21. Signature of Funeral Service Ligense 6160 Oxon Hill Road Oxon Hill, Maryland 20745 Approximate Interval Between Onset and Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Death a. Positional Asphyxia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and sician/Medical AMENDED #1as notated, perME, G909, 11/10/2010, WS UNPENDED ending physician use as the burial The law requires that the death certificate be Box 68760 23d. Date of deliven IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 2 Fetal death Year 3 Ectopic pregnancy Month Day Live birth past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 V No 9 Unknown Unknown P 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown ğ Completed certificate has been s ector, page 2 should 24a. Was an 24b. Were autopsy findings available pnor to completion of cause of death? performed? ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: æ examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other Scene this 1 🗸 Yes 28a. Date of Injury FOUND: 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury After 27. Manner of Death Certification: Partially fell out of bed **FOUND** Natural Natural 1 5 Pending 1 Yes 2 V No 24 hours after death. Director: d in by the Oct 7, 2010 0550 hrs Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 Could not be 3 Suicide or Town, State) 5715 Plata Street, Clinton, MD determined (Specify) Single Family Home To the Funeral completely filled Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 8, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Carol Allan, MD 32. Registrar's Signature

DHMH 17 Rev 1/2001 **OCME 2006** 

State Registrar

31. Date filed (Month, Day, Year)
OCT 1 3 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 33554 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8° 29AM 11200CC Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** Duck age (In yrs. last birthday) If Und 8. Date of Birth **Funeral** 1 🔀 M 2 🗆 F Months Hours Aug. 24, 1914 New Cour York 96 Director 085-03-9999 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State with the Maryland items 23a or 28a-f sho ner must be notified at Director Chevy Chase MD Montgomery 1 XYes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 20815 United States 3214 Pauline Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or Noıral", or iten I Examiner n 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinone. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give WW II 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Legal Patent Attorney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Schott Fanny Joseph E. Field 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David R. Field/Son 1820 Sonoma Ave. #46, Santa Rosa, CA 95405 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Geo. Wash. University 1 Burial 2 Cremation 3 Removal from State Washington, D.C. 2010 4x Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Columbia Mortuary Services, P.A. 21 Signature of Funeral Service Licenses /M00969 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 1 Yes 2 9 Unknown s been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has be 2 s Hospital or Attending Physician: The law autopsy this certificate 2 🗆 No Yes **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 🗌 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b, Signature and title of certifier completed cause of deat me and address of person State

Registrar

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State Registrar		State	e of M	arylan	a/D	epartm C <i>ertific</i>	ent of F ate of L	Health and I Death	Mental Hy	/gien Reg. N	_ 0 . 0	33	555
Dharisis		Decedent's Name	e (First, Middle	e, Last)	_						2. Date of De	eath		3. Time	of Death
Physicia Medic		Lucille B									Octobe		2010		20 A M
Examin	er	4a. Facility Name (if 110 River		, give street and	number)				ity, Town, or gewate	r Location of Death	1		c. County of Deat .nne Arur		
Funeral Director		5. Social Security No. 578–24–8	umber	6. Sex 1 \( \text{M} \) 1 \( \text{X} \)	1-1	e (In yrs. Ia	st birtho	ay) If Ur	der 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D 8/26/	rth	g. Birt		e or Foreign
d d	_	Usual Residence of 10a. State	Decedent 10b. County				Town	r Location			-7.==7				City Limits
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To the Hospital or Atten within 24 hours after deat To the Funeral Director: completed filled in by the	Medical	29a. Certifier 1 (Check 2	Certifying	Physician: To the	he best of	my knowle	edge, de	ath occured	at the time	, date and place, a	nd due to the ca	ause(s) a	nd manner as sta	ted.	manner stated
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DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day toxwel October 2610 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Baltimore City** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | APRIL 5, 1989 . Age (In yrs. last birthday) 1 **X** M 2 □ F Yrs MARYLAND 21 10c. City, Town or Location QUEEN ANNE'S STEVENSVILLE 10f. Zip-Code 10g. Citizen of What Country? 21666 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dak 009-2010 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 ☐ Yes 2X No Specify: Specify: WHITE 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) ARMY NATIONAL GUARD **MILITARY** 18. Mother's Name (First, Middle, Maiden Surname) KELLY LYNN PINKINE

**Examiner** The Johns Hopkins Hospital Birthplace (State or Foreign
Country) 5. Social Security Number **Funeral** 217-25-2049 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 1 Yes 2X No Director MARYLAND 10e. Street and Number 314 LARCH PLACE by Funeral 11. Marital Status 1 Never Married 2 ☐ Married 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) Be TERRY JAY FOXWELL မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KELLY L. BUNCH/MOTHER 314 LARCH PLACE, STEVENSVILLE, MD 21666 20b. Place of Disposition (Name of cemel DORCHES LER Place)
MEMORIAL PARK 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 15 CAMBRIDGE, MD 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 SOUTH LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) tcell Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 2 No 3 Probably 4 Unknown 1 🗌 Yes

**Physician** /Medical **Examiner** 

attending physician and I for use as the burial-transit

Box 68760

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Records,

**Division of Vital** 

1 - For State Registrar

Kyan

**Physician** 

ms 23a or 28a-f show must be notified at

items 23a

ed other than "natural", or iter event, the Medical Examiner

marked other than

of Health

/Medical

Completed 24a. Was an autopsy performed? 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 \sum Nursing Home 2 No 1 \sum Yes 3 DOA 2 ER/Outpatient 5 Residence 6 Other (Specify) ၉ 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 🗌 Yes 2 🗌 No 2 Accident 3 
Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier (check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

State

completely filled in by the funeral director,

this

i or Attending P after death. Director: After ti

To the Hospital within 24 hours a To the Funeral D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

egistrar's Signatur

000Uctober 11, 2010

600 North Wolfe St, Baltimore, MD, 21287

24b. Were autopsy findings available prior to completion of cause of death?

1 Tyes

2 No

Registrar

RES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 33557 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month OCTOE GLENN 2010 8:36 P M HAROLD FOGLE Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death FREDERICK MEMORIAL HOSPITAI FREDERICK . Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 1 M 2 □ F 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Jan. 7, Months Hours 220-18-1158 84 Mary Land Director Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1√2 Yes 2 ☐ No Maryland Frederick Walkersville 10e. Street and Number 10g. Citizen of What Country? Funeral 3 Charles Street 21793 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed 3 X Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Owner & Operator Electrical Business Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Eugene Fogle Emma Fox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jim Fogle / Son 8407 Cub Hunt Court, Walkersville, MD 21793 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemeterv 10/12/2010 Walkersville, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, 23a. Part Lefter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 24 hours after death Funeral Director. filled in by

2		d						
y sicially lan	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregr 1  Live Birth 2  Fe 4  Pregnant at time of 9  Unknown	tal death 3 🗌 Ectopic			23d. Date of de Month	elivery Day	Year
5	Part II. Other significant conditions	contributing to death but not re	esulting in the underlying	cause given in Part I.		use contribute to		
2					1 🗆 Yes	2 □ No 3 <b>X</b> F	robably 4	Unknown
					24a. Was an autopsy performed?	death?		of cause of
	25. Was case referred to medical			26. Place of Death (Che	eck only one)			
	examiner? 1  Yes 2 No	Hospital: 1 Inpatient 2	SER/Outpatient 3 🗆	OOA Other: 4 I Nursing	Home 5 Residence	6 ☐ Other (Spec	cify)	
2000	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigat		28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred		
	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	1 28a Place of Injury At h	nome, farm, street, facto fy)	ry, office	28f. Location (Street a City or Town, Sta		ıral Route N	umber,
5	(Check 2 Medical Exa	nysician: To the best of my know miner: On the basis of examination	on and/or investigation, in	n my opinion, death occurred	at the time, date and place	ce, and due to the	ated. cause(s) and	d manner stated.

D0030020

Walkersville, Md

29d. Date signed (Month, Day, Year)

2010

DHMH 17 Rev 7/2009

State Registrar

10

29b. Signature and title of certifie

John 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State	of Marylar		artment of		and M	lental Hyg	jiene			
			Registrar	t		Cer	tificate of	Death			leg. No		3355	8
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	edica mine	_	Yvonne Mari 4a. Facility Name (If not institution,		mber)		4b. City, Town,	or Location	of Death	10 -	4c. County			IVI
		71	248 Ocean Parkw					Pines				cest		
Fune			5. Social Security Number	6. Sex 1 ☐ M 2 🕱 F	7. Age (In yrs.		If Under 1 Yea Months Days		24 Hrs. Min.	8. Date of Birth		9. Birth	place (State or Foreig	ign
Direc		ŀ	177-48-9606 Usual Residence of Decedent		54	Yrs.				2/25/1	956		CA	
land show	ā	គ្ន	10a. State 10b. County		10c. Ci	ity, Town or Loc	cation						10d. Inside City Limit	its
Mary 28a-f		Director		ester	0	cean Pi	.nes						1 ☐ Yes 2 🔀 I	No
th the	100	ョ	10e. Street and Number				10f. Zip Code				10g. Citizen of	What Cou	ntry?	
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Viana Id be filed Mental Hyg larked oth	, aver		17. Father's Name (First, Middle, La	ast)				18. Moth	er's Name	(First, Middle, N	Maiden Surnam	e)		
Lyia uld be il Meni narke	anc	의	Joseph Mazzola			1				Unknown				
Mar 2 shou 1th and 27 is n			19a. Informant's Name/Relationsh Brian Flint /	1 37		1	g Address (Stree Ocean P				-	•	•	
Te, 1 and of Heal		ŀ	20a. Method of Disposition			Place of Dispos	sition (Name of				20c. Location			
Page nent c	5		1 ☐ Burial 2 ☐ Cremation 4 ☐ Contact Specifier (Specifier)		Clate		atory or other pl Gifts Re		10/8	/2010	Hanover	, MD		
bartimore, imaryland 2.12.13-0030 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", or items 23a or 28a-f show minimum or after the province of the result of the province of t	once.		21. Signature For al Sovige Li	censee		22	Name and Add	ess of Facilit	y Bur	bage Fu	neral H	lome		
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requi requi		lete								24a. Was ai			psy findings available	
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Physic Physic this ca		၉	1 Yes 2 No  27. Manner of Death		Inpatient 2		t 3 🗆 DOA			ne Reside			)	
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DIVISION OF VITAL RECORDS, F.O. BOX 08/00  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		Medical	(Check 2 U Medical Ex	Physician: To the b caminer: On the bas Nurse Practioner:	sis of examinatio	on and/or invest	igation, in my opir	ion, death oc	curred at	the time, date an	d place, and du	e to the car	use(s) and manner sta	ated.
To the			29b. Signature and title of certifier				29c. Licen	se number		2	9d. Date signe	d (Month, i	Day, Year)	
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	State istra	=	31. Date filed (Month, Day, Year)  OCT 1	- 0014	Registrar's Signa	A. A	back							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 9 Day 2010 Year Physician/ 8:48 p Helena Gottlieb Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Country) Kosice Czechoslovakia 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 🛣 F 1270971927 **Director** 82 077-24-5232 Usual Residence of Decedent "natural", or items 23a or 28a-f show odical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Silver\_Spring Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 2309 Manor Spring Terrace 20906 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc Completed by 1 Never Married 2 Married Yes 2 XNo Maryland 21215-0036 White 1 ☐ Yes 24 ☐ No Specify: If Yes, Give Specify: 3 ¥ Widowed 4 □ Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Pupil Accounting 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) New York City and Mental Hygiene. is marked other than "unknown some Elementary/Seconday (0-12) Accounting Secretary Board of Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Firda Gewürtz Herman Nussenzweig permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Silver Spring, MD 20906 <u>Sandra Landis, daughter</u> 2309 Manor Spring Terrace, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gdns 10/12/2010 Olney, Maryland . Signature of Funeral Service Licensee 22. Name and Address of Facility
EDWARD SAGEL FUNEAL DIRECTION,
1091 Rockville Pike, Rockville (ANTO MO1255 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician. Cardiac Arrest disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any course is conditions, cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of the burial-tr that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician the for use as the burial Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 2 🔀 No 1 ☐ Yes 2 \$ 9 ☐ Unknown should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Gastrointestinal Bleed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Yes 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) **Division of Vital** completed filled in by the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No ၉ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1x Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1 October 09, 2010 H0067499

Registrar

State

GOTHIED 10191

telena

Christine Castro, DO, 8600 Old Georgetown Road, Bethesda, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

OCT 13 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month  $P^{M}$ Lucille Gordis October 2010 2:40 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Manorcare Potomac Nursing Home Potomac Montgomery

9. Birthplace (State or Foreign Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 🛛 F Months Hours Min. 09/23/1933 Country) Director 132-26-5928 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No MD Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20854 10714 Potomac Tennis Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify. 3 Divorced 4 X Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed withi.
Department of Health and Mental Hygiene Important; If item 27 is marked other that any injury or other trainmatt. <u>Teacher</u> Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Irving Sapirstein <u>Maria Liebmann</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Deborah J. Gordis / Daughter</u> <u>5909 Kingsford Place Bethesda, MD 20817</u> 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Westchester Hills Cem: 10/08/2010 <u>Hastings on Hudson, NY</u> 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Danzansky-Goldber 1170 Rockville Pi rg Memorial C ike Rockville Chapels Blake 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Advanced Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) the: cate has been signed by tage 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No certificate 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 🗶 No ဂ္ဂ 1 Inpatient 2 I ER/Outpatient 3 DQA within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work 1 🗌 Yes 2 🔲 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis or examination allows investigation, intring opinion, search search and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifier

<u>Sunitha Bhogavilli</u>

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

.D

DHMH 17 Rev 7/2009

Georgia

9801

D0054566

October 06.

Ave. #1-17 Silver Spring, MD 20902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10a-f Per INF G914 4/01/2011 H State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 11 2010 Joseph Donald Gelb 6:50 AMM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Fox Hill Assisted Living Bethesda Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 12M9113 94923 Wilkes Barre PA 146-18-4875 86 Yrs. Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Broward HD FL Pompano Beach 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 525 N. Ocean Boulvard Funeral 33062 20854 United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Baltimore, Maryland 21215-0036 þ 1 Never Married 2 Married 1 ₩ Yes 2 No If Yes, Give WW II Year or Dates. 1 ☐ Yes 2 😾 No Specify: Specify: White Completed 3 XWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. ' **∼ther than** " College (1-4 or 5+) 5+ Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other that any injury or other traumatic event, the 1 once. Lawyer Law Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Edward Gelb Esther Fierman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adam Gelb - son 11513 DahLia Terrace Potomac MD 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Judean Mem. Grdns 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/13/10 Olney, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral \$ 22. Name and Address of Facility M01163Edward Sagel Funeral Direction Inc. 1091 Rockville Pike Rockville MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Sepsis Medical Due to (or as a consequence of) Examiner Severe Periphial Vascular Disease Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 F FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Dav Year Yes 2 No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Coronary Artery Disease peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2**X** No Other: 1 🗌 Yes ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending injury 1 Yes 2 No Investigation Suicide 6 Could not be 3 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. The continuence of the section of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) D13818 October 11, 2010 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (N

Gary Fisher MD 5530 Wisconsin Avenue Chevy Chase MD 20815

Registrar's Signatur

company

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 0315 0 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Mandrin House Anne Arundel Harwood 8. Date of Birth (Month, Day, Year) Mar 8, 1921 If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1 🗆 M 2 🗹 F Months Hours Min. Director 89 144-14-1139 Germany Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director Maryland 1 😾 Yes 2 🗌 No Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 931 Ships Bell Court 21401 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 No Maryland 21215-0036 1 Yes 2 No Specify: "natural", Specify: 3 X Widowed 4 ☐ Divorced Year or Dates. White : If item 27 is marked other than "natur or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u>Bookkeeper</u> Retail age 1 and 2 should be filed w int of Health and Mental Hygi t: If item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Bernard Pilz Weichelt Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra A. Cruder/daughter 514 Heavitree Garth Severna Park, Maryland 21146 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State cemetery, crematory or other place) permit, Page Department or Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 10/14/10 Woodbine, Maryland Sign Pre of Funeral Service Licer Going Home Cremation Service P.O. Box 784 Thomas M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Te to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed lined in by the innerial director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) Month Year Day 9 Illnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurre 160 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation HOUS, Accident ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the dest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. A samination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier address of pers death (Item 23a) (Type, Print

State Registrar Date filed (Month)

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1076/2010 4:45 MARY M. Gulledge AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death ROSA NURSING HOME MITCHELVILLE PRINCE GEORGE'S 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Hours Min Months Director Statesville, NC 89 245-34-5486 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Ty Yes 2 No Maryland Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15609 Cheswicke Lane 20772 United States 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 X Divorced Completed Specify: **Black** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9th Domestic Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Thomas Adams Mamie Davie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Smith / Daughter 15609 Cheswicke Lane Upper Marlboro, MD 20772 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/12/2010 | Brentwood, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, MD 20747 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death YEARS Immediate Cause (Final Physician, METASTATIC TERMINAL ESOPHAGEAL CARCINOMA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner DEMENTIA YEARS Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or linjury that initiated events resulting in death) Last HYPERTENSIVE CARDIOVASCULAR DISEASE EARS and-trar Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed No 3 ☐ Probably 4 ☐ Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 🔽 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 **X** No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 😾 Nursing Home 5 □ Residence 6 □ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work thin 24 hours after death.

the Funeral Director: At properties in by the function of the following the following in the following the following in the followi 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

within 2 To the F

Registrar DHMH 17 Rev 7/2009

State

Medical

29a. Certifier

29b.

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31. Date filed (Month, Day, Year

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Arora,

3 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

10/11/2010

D20108

14300 Gallant Fox Lane Suite 222 BOwie, Maryland 20715

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland	•	ertment o		and M	ental Hy	giene Reg. No	0 + 0	33564
	<b>.</b>		1. Decedent's Name (First, Middle, Last)		** "				2. Date of De	ath	/ Year	3. Time of Death
	Physici: /Medic		MARY	SHAW		GIBBS			OCTOBE	_		8:30 P <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Towr	n, or Location o	of Death		4c.	County of Death	
sh the			BRADFORD OAKS NUF			CLINT		24 Hro T	0. D-1(D)		PRINCE G	
	Funeral		5. Social Security Number 6. Sex 1 □	7. Age (In yrs. last M 2 ☑ F 85	Yrs.	If Under 1 Ye Months Da		Min.	8. Date of Bir (Month, D	ay, Yea <i>r)</i>	Cou	place (State or Foreign ntry)
	Director		Usual Residence of Decedent						MAY 21	192	5   NORT	H CAROLINA
	yland Now		10a. State 10b. County	10c. City, T	own or Loc	cation					1	10d. Inside City Limits
	Mar med st	ctor	MD PRINCE GE	ORGE'S UP	PER M.	ARLBORO	1					1 XYes 2 ☐ No
	or 28	Director	10e. Street and Number	7011011 D		10f. Zip Cod				10g. Cit	izen of What Cou	ntry?
	death with the Maryland ims 23a or 28a-f show		8502 BISCAYNE COUR	RT		2	0772			US	A	
	tems	by Funeral	TT Maritar Diales	2. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of Yes, specify C	of Hispanic Ori Cuban, Mexican	gin? (Spe n, Puerto F	cify Yes or No Rican, etc.)	)-	<ol> <li>Race - Ameri Black, White,</li> </ol>	
9	s afte	χF	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ⊟Yes 2 No If Yes, Give	1	∐Yes 2√∏1	No Specify:				Specify: BI	ACK
3-003b	within 72 hours after dea lene. than "natural", or items he Medical Exeminer in		15. Decedent's Educa	Year or Dates:	6a Decer	lent's Usual Oc	cunation			16b Ki	ind of Business/In	ndustry
3	iin 72 n "na Necho	Completed	(Specify only highest grade	completed)	(Give I	kind of work do OO NOT use re	ne during most tired)	t of workin	g			
717	d with giene gr tha	mo	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	TEA	CHER					GOVERNM	IENT
ם כ	be filed within 72 hours after death with the Marylan Hygiene. All Hygiene, and Hygiene, and other than "natural", or items 23a or 28a-f show event, the Madical Examiner must be notified at	BeC	17. Father's Name (First, Middle, Last)				18. Mothe	er's Name	(First, Middle	, Maiden		
<u>a</u>	should be nd Ments marked matic ev	To E	WALTER SHAW					LEN	A BLAC	KWEL	L	
Mar	au au		19a. Informant's Name/Relationship (Typ	,							or Town, State, Zij	•
	s 1 and 3 of Health Item 27 other tr	1 8	PALMELA GIBBS BURGE	<u> </u>								AND 20772
_	ges 1 t of H Hite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	moval from State 20b. Plac	e of Dispos etery, crem	sition (Name of natory or other	place)	Da	ate	20c. Lo	ocation - City or To	own, State
	permit. Pages Department of Important: If It any Injury or one		4 ☐ Donation 5 ☐ Other (Specify)	RESU		TION CE					NTON, MAR	
Dait	Depar Mpol Mpol any ir	, į	21. Signature of Funeral Service Licenses	( Lil								HOME, INC.
			23a. Pay 1. Enter the disease, or complic	otions that coursed the death							ARYLAND	20785
		8 1	shock, or heart failure. List only one	cause on each line.				cardiac o	respiratory a	111651,		Approximate Interval Between Onset and Death
All I	hysician /Medical		disease or condition resulting in death)	ATHEROSCLERO		HEART D	ISEASE					
ع الجيم	xaminer			Due to (or as a consequen	ce or):							
	- 5	Jer	Sequentially list conditions, if any leading to immediate	Due to (or as a consequen	ce ofj:							
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events									
, ,	e exe ian ar irial-ti	EX	resulting in death) Last	Due to (or as a consequen	ce of):							
0/0	cate be executed physician and the burial-transit	dical	d.									
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ם מס	ath cather	sician/M	23b. Was decedent pregnant in the past 12 months?	<ul> <li>c. If yes, outcome of pregnancy</li> <li>1 ☐ Live birth 2 ☐ Fetal de</li> </ul>	ath 3 🗆	Ectopic pregn					23d. Date of deliv Month	/ery Day Year
5	the a	ysic	1 □Yes 2 🖾 No 9 □ Unknown	4 ☐ Pregnant at time of deat 9 ☐ Unknown	n 5∟	Other (specify	<i>'</i> )					,
r.	w requires that the death certin s been signed by the attending i should be detached for use as	Phys	Part II. Other significant conditions cont	ributing to death but not resulting	g in the un	nderlying cause	given in Part I.		23e. Did	tobacco i	use contribute to	the cause of death?
S.	sign d be	d by	•		9	, , ,	<b>3</b>		1 🗆	Yes 2	☑ No 3☐ Pro	bably 4 🗌 Unknown
Hecords	v requ	Completed					-		24a. Was		1	opsy findings available
ב ב	e has	mp							auto			ompletion of cause of
VIII	tificat tificat or, pa	ပို	25. Was case referred to medical				06 Plans	of Dooth	1 Yes	2 <b>X</b> No	1 □ Yes	2 <b>X</b> No
5	Attenuing Privsician: The law or death.	B	examiner?	spital: 1 ☐ Inpatient 2 ☐ ER	/Outnatien	t 3 DOA	Othor:		(Check only		6 □Other (Spec	i6.)
5	g rm erthi	n: To	27. Manner of Death	28a. Date of Injury 28	b. Time of	28c. I	njury at		8d. Describe			ny)
5	ath. ir: Aff	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury		Vork? I∐Yes 2∐I	No				
2 3	er de recto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	et, factory, offic	ce	2	8f. Location City or To	Street ar	nd Number or Run	ral Route Number,
5 5	iral or ral Di led in	Cer		, , , , , , , , , , , , , , , , , , , ,						,		
000	Funer Funer tely fil	edical	(Check only 2 Medical Examin	cian: To the best of my knowle er: On the basis of examination								
4	on the pospinal or Attending Priystolan: The law requires that the death certificate that both and a start death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Med	29b. Signature and title of certifier	and manner stated.		29c Lie	ense number			29d Da	te signed (Month	Day Year)
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	7		20 Name and address of account	enlated agues of doubt (literation	) (Tu *		5206			OCT	OBER 12,	2010
_	1	l J	30. Name and address of person who con WILLIAM TANNER M.I		, , , , ,	•	101 FC	ORT W	ASHING	TON.	MARYLANI	20744
	Sta	te	31. Date filed (Month, Day, Year)	`62. Registrar's Signature		10111	101 10	11				
	Registr		OCT 1 9 2010 /2	A AL	Med							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM# Sper INF, G910, 12/17/2010, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar 33565 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Offaher 5.08 PM 2010 len Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prin TOID anham 8. Date of Birt 2-22-1933 6. Se Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace State or Foreign **Funeral** Day, Year) 1 🗆 M 2 🖼 Months Days Hours Min. (Month, Director 220 40 6545 Marzala Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No Prince Marzhand 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3624 luwer 20613 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 Yes 2 No Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 Yes No Specify: Specify: Black 3 🛚 Widowed 4 🗆 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homens 12 imest Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Butter Rob. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robinson 7506 MI wining 20775 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Resurection 4 Domation 5 Other (Specify) 10-18-10 Clinton M. 21. Signature of Juneral Service Licer 22. Name and Address of Facility ş mois 2008 23a. Part V. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Ph\_sician/ Metastahe Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of, attending physician and I for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has funeral director, page 2 s autopsy performed? Yes 2 ■ N 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗖 No 1 🗌 Yes မ 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending iniury work?
1 Yes 2 No in 24 hours after death.

In Funeral Director: A pleted filled in by the fu Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29b. Signature and tit 29c. License number 29d. Date signed (Month, Day, Year) 10-10-10 D45660 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address CALLANT 31. Date filed (Month, Day, Year) Registrar's Signature State OCT 1 3 2010 Registrar

		Pleas	se Type or Print in I						-			
	State of Maryland / Department of Health and Mental Hygiene									00566		
		State Registrar Certificate of Death					· · · · · · · · · · · · · · · · · · ·	Reg. N2010 33566				
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Examin	er	, ,	s Hospital			r Location of Death r Sprin			County of Deat			
Funeral			5. Sex 7. Age (In yrs. Ia	ast birthday)	If Under 1 Year		8. Date of Bi	rth		thplace (State or Foreign		
Director		490-38-8901	1 □ M 2X F 8 5	Yrs.	Months Days	Hours Min.	May 1	ay, Year) 8	Co	untry)		
d tow	L	Usual Residence of Decedent  10a. State 10b. County	100 Cit	v. Town or Lo	eation					10d. Inside City Limits		
vith the Maryland 23a or 28a-f show ist be notified at	cto	MD Prince Georges Hyattsville								1 Yes 2X No		
or 28	Dire	10e. Street and Number			10f. Zip Code		-	10o C	itizen of What Co			
with t	Funeral Director	10403 Edgefi	eld Drive		2078	3		_	JSA	,		
rs after death with ural", or items 23a Examiner must b	Fun	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	3. 13.	Was Decedent of H	Hispanic Origin? (Span, Mexican, Puert	pecify Yes or No		14. Race - Ame			
", or	by	1 Never Married 2 Marrie	ed 1 ☐ Yes 2 🔀 No If Yes, Give		1 ☐ Yes 2 🛣 No		o Alcan, etc.)		Black, White	e, etc.		
filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho ivent, the Me acal Examiner must be notified at	Be Completed	3 ★Widowed 4 ☐ Divorced  15. Decedent*						ite				
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shou and is m raum		19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street	and Number or Ru	ral Route Numb	er, City o	r Town, State, Zij	o Code)		
and 2 Health		Robert A. Ha 20a. Method of Disposition				view Dr				ID 20872		
ge 1 and the state of the state		1 🗆 Burial 2 😾 Cremation 3	Removal from State	emetery, crei	osition (Name of matory or other place		Date		ocation - City or			
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perm Depe Impo any i		Francis J. Collins Funeral Home, Inc.										
		23a. Part 1. Enter the disease, or co	omplications that caused the death						ші <b>у,</b> по 2	Approximate		
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ysicie is cert direct	To B	examiner? 1  Yes 2  No	Hospital:	ER/Outpatie	Oth	er:		idence	6 Other (Spec	ifv)		
ng Ph fter th neral		27. Manner of Death 1   ↑ Natural 5 □ Pending	28a. Date of injury	28a. Date of injury 28b. Time of 28c. Injury at					y occurred			
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or Attending Physician: The law requires that the death certificate be after death.  Director: After this certificate has been signed by the attending physici in by the funeral director, page 2 should be detached for use as the bu	Certificate:	4 Homicide determin		ome, farm, str	eet, factory, office		28f. Location ( City or To			ral Route Number,		
spital tours teral i		29a. Certifier 1 Certifying P	Physician: To the best of my knowl	ledge, death	occured at the time	date and place a	and due to the co	ause(s) a	nd manner as st	ated		
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has eempleted filled in by the funeral director, page 2 to a completed filled in by the funeral director, page 2 to a completed filled in by the funeral director.	Medical	Check 2 ☐ Medical Exa	aminer: On the basis of examination lurse Practioner: To the best of my	n and/or inves	tigation, in my opini	on, death occurred	at the time, date	and place	e, and due to the	cause(s) and manner stated.		
Withi # 10	-	29b. Signature and title of certifier		1	29c. Licens				ate signed (Monti			
10		Halas	isouny, 1	1 1)	Do	0672	79	Octo	ber 10, 2	010		
		30. Name and address of ceson who completed cause of death (Item 23a) (Type, Print)  Suganthi A. Veerappan, MD 1500 Forest Glen Road, Silver Spring, MD 20910										
Stat	e	31. Date filed (Month, Day, Year)	2. Registrar's Signat	ture		эргия, М	703TO					
Registra		OCT 1 3 20	10 Sentra S.	par	4.3.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33567 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month AS 1105 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 717 Whitehall Plains Road Annapolis Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 □ F (Month, Pay, Year) eb 17, 1931 Months Hours Min. Washington, DC Director 382-24-6181 79 Feb Usual Residence of Decedent show 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Anne Arundel Annapolis 10e. Street and Number 10g. Citizen of What Country? Funeral 717 Whitehall Plains Road United States 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Black, White, etc. ģ 1 Never Married 2 😾 Married 1 ☐ Yes 2 🔀 No Specify: and Mental Hygiene. is marked other than "natural", 3 Widowed 4 Divorced Specify: Completed Year or Dates. 1954-62 White event, the Me lical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Airline Pilot Aviation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John K. Hinson Marion Vail permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Lee Hinson/wife 717 Whitehall Plains Rd Annapolis, Maryland 21409 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Final Journey Crematory 10/12/10 Woodbine, Maryland 21. Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 any M00957 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final EART Physician/ DISEASE disease or condition 1ears Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): resulting in death) Last physician Completed by Physician/Medical attending ph for use as th IF FEMALE: 23c, If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year signed by the a 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? FIBRILLATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🚾 Unknown CerebrovAscular DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No Hospital or Attending Physician: The 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident s after death. 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined To the Hospital of within 24 hours a To the Funeral D Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie ,24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

21215-0036

Baltimore, Maryland

Box 68760

Records,

Division of Vital

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State Registrar	State	of Maryla		artment o <i>tificate o</i>		and N		giene Reg. No. /	2010	33568	
Dhyoini	/	Decedent's Name (First, Middle,	, Last)			-			2. Date of Dea	ath	Veer	3. Time of Death	
Physicia Medi	cal	Randy Lee							Octobe	<del></del>	2010 <sup>ear</sup>	10:50 P M	
Examin	ner	4a. Facility Name (If not institution,	give street and n	umber)		4b. City, Towr				4c. Co			
Funeral	-	5. Social Security Number	6. Sex		Rockville  If Under 1 Year   If Under 24 Hrs.   8. Date of E			:h	Montgo 9. Birt	hplace (State or Foreign			
Director		579-82-7689 Usual Residence of Decedent	1 🔀 M 2 🗆 I	46	Yrs.	Worldis	ys Hours	Min.	OCT 16	<b>",</b> "196	3 Mas	sachusetts	
and show	o	10a. State 10b. County		10c. C	ity, Town or Lo	cation						10d. Inside City Limits	
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of											
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2 should be filed th and Mental Hy 27 is marked oth traumatic event	2	Bruce Wayn	e Harv	wood			Ma		Concet		Chenau	lt	
shoulk and N is ma		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Addre					eet and Number or Rural Route Number, City or Town, State, Zip Code)						
and 2 Health tem 27		Mary Harwood/m 20a. Method of Disposition	other	20h	14103 Place of Dispo		Avenu		andywin	•			
Page 1 nent of ant: If it ury or o		1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other (S)		om State	cemetery, cren	natory`or other p			Date		dhine		
permit. P Departm Importal any injul		4 Donation 5 Other (Specify)  Final Journey Crematory 10/08/2010 Woodbine, Maryland  21. Signature of Funeral Service Licenses  Coing Home Cremation Service P.O. Box 784											
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requires that the death certificate be expensed in the death certificate be expensed by the attending physician should be detached for use as the burial	Physician/Medical	d											
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death of atter	sicial	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 □ Pi	1  Live Birth 2 Fetal death 3  Ectopic pregnancy 250. Date of 0 Pregnant at time of death 5  Other (specify) Month 9  Unknown								Day Year	
at the d by the etache		9 Unknown	nown significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of the							the cause of death?			
irres th signe	d by	Take in State of the angle of t							1 Yes 2 No 3 Probably 4 Unknown				
aw requas beer 2 should	Completed								24a. Was	Was an 24b. Were a autopsy prior to		topsy findings available	
The la ate ha page 2	Com								perfo	rmed?	death?	2 No	
ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:				. Place of Dea			7.25			
Phys er this eral dir	е: То	1 ☐ Yes 2 🔀 No 27. Manner of Death	28a. Da	Inpatient 2 Late of injury	28b. Time of	28c Injury at 28d Describe how injury occurred					ify) Hospice		
Attending Physician: The law requires that the death certificate be at deep. Attending physician: The law requires that the death certificate be actor. After this certificate has been signed by the attending physicial by the funeral director, page 2 should be detached for use as the business.	Certificate:	1 X Natural 5 ☐ Pending 2 ☐ Accident Investig 3 ☐ Suicide 6 ☐ Could r	ation	onth, Day, Year)	injury	work?  M 1 □ Yes 2 □ No							
al or Att after d Direct d in by		4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)								on (Street and Number or Rural Route Number, Town, State)			
To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director, After this completed filled in by the funeral di	Medical	29a. Certifier (Check only one)  1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 **Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								cause(s) and manner stated.			
To the vithir To the comp	2	29b. Signature and title of certifler			.,	29c. License number				29d. Date signed (Month, Day, Year)			
ı		161	dress of person who completed cause of death (Item 23a) (Type, Print)							10-7-200			
3		30. Name and address of person v G. Coleman, M.	-				lle.Ma	rvla	nd 2085	0			
Sta Registr		31 Date filed (Month Day Year)		. Degistrar's Sign	atuma.	arke		<u>- y 10</u>					
negisti	en .	30.20			1. 1								

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Maryland	•			/lental Hygi	ene			
		_	State Registrar	Certificate of Death			Death	Re	g. No. 2	2010 33		
	Physicia Medic		1. Decedent's Name (First, Middle, Last)	AVERNI				2. Date of Death		10	3. Time of Death 05/5 M	
	Examin		4a. Facility Name (if not institution, give st	·			Location of Death		4c. County			
Ξ.			Mandrin Hospice Hospice Hospical Security Number 16. Sex		at hirthday)	Ha If Under 1 Year	rwood If Under 24 Hrs.	8. Date of Birth	<u> </u>		Arundel  lace (State or Foreign	
	Funeral Director		129-28-2621	1M 2 <b>X</b> F 73	Yrs.	Months Days	Hours Min.	(Month, Day, 12/6/19	Year)	Count	York	
	, wc	Funeral Director	Usual Residence of Decedent			-		12/0/1				
	rryland 1-f sh ied at		10a. State 10b. County New York Queens	10c. City,	Town or Loc		+			110	od. Inside City Limits  1   Yes 2   No	
	he Ma or 28a o notif	Dire	New York Queens  10e. Street and Number		Long	Island Ci	LLY	11	Og. Citizen of W	/hat Count		
	with t	eral	39-36 28th Street			11101			USA		,	
	items items		11. Marital Status	Was Decedent Ever in U.S. Armed Forces?		Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp		14. Race	e - America k, White, e		
36	after Il", or xamir	Completed by	1  Never Married 2  Married 3  Widowed 4  Divorced	1 ☐ Yes 2 🏋 No If Yes, Give	1	☐ Yes 2 🕅 No		,,	Specify:	Whi		
8	hours natura ical E	lete	15. Decedent's Edu		16a. Deced	ent's Usual Occup	ation	1	l6b. Kind of Bu			
215	in 72 e. nan "r Med	dwc	(Specify only highest grade Elementary/Seconday (0-12)	completed) College (1-4 or 5+)		kind of work done o O NOT use retired)	luring most of work	ing			,	
7	d with lygien ther th	Be Co	12th		Med	ical-Offi					Field	
Maryland 21215-0036	oe filed intal H ced ot	To B	17. Father's Name (First, Middle, Last)  Samuel James Ha	avarn				e (First, Middle, M. rtha Ann		)		
Ž	ould the mark mark		19a. Informant's Name/Relationship (Type		19b. Mailir	g Address (Street a				tate. Zip C	ode)	
Š	d 2 sh alth a 1 27 is ertra		Margaret M. Staed/	·		Wanderin			•			
ore,	of He of He if item		20a. Method of Disposition 1 X Burial 2 Cremation 3 R		ace of Dispo metery, cren	sition (Name of natory or other plac	e)	Date 2	20c. Location -	City or Tov	wn, State	
Baltimore,	Pag tment tant: jury o		4 Donation 5 Other (Specify)	St.		Neri Cemet			Northp			
Bai	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature Furreral Service Lio Seed 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037									
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus ach line.  Approximate Interval Between									
	Pnysician/ Medical	9 1	Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):								Onset and Death	
	Examiner											
		iner	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	ence of):	of):						
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_	certificate be executed inding physician and use as the burial-transit	dical E	resulting in death) Last	Due to (or as a conseque								
760	cate to	edic	d	•								
89	eath certifice attending p	an/N	23b. Was decedent pregnant	Bc. If yes, outcome of pregnan		Ectopic pregnanc	A.		23d. Dat	l. Date of delivery		
Вох	9 9 9	Physician/Me	in the past 12 months?  1 Yes 2 No	Other (specify)	· y		Month Day Year					
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ord	v requ	olete	24a. Was an 24b. We							Vere autop	sy findings available	
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<b>\S</b>	ding Physi h. After this c funeral dire	2	1 Yes 2 No	1 🗌 Inpatient 2 🗀 E	R/Outpatier	ot 3 DOA Othe	4 ☐ Nursing Ho	ome 5 Resider		-	MANDKIN	
Division of Vital	nding I tth. : After e funer	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	work	Yes 2 No	28d. Describe how	v injury occurre	ia .	170030	
<u>ISIC</u>	r Attendii er death. ector: Ai by the fu	Certificate:	3 Suicide 6 Could not be						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
á	ital or urs aft ral Di											
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
_	To th Withir Comp	2	29b. Signature and title of certifier	/0 >	-3-1	29c. License			d. Date signed			
	)		Xusan H. f	reegek, n	ib	124	1838		10/0	6/1	0	
1	1160		30. Name and address of person who con	npleted cause of death (Item	23a) (Type, P	t Dofe	enso L	fine L	ena n	elis	mn 2/4/	
	Stat	te	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	7 ( )	<i>y y y y y y y y y y</i>		wy /	, agn	-us,	1.100170	
	Registra		OCT 0 8 201	10 Senera	B. S	arkel		/				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER 9 ay 2010 a RUTH CELIA HEMMER 5:15  $\mathbf{P}$  M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CAROLINE HOME FOR HOSPICE DENTON CAROLINE 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🕱 F Months Hours Min. SEPT .3, 1917 NEW YORK 93 Director 126-32-5057 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 □ No MARYLAND TALBOT **EASTON** 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 640 MECKLENBERG AVE. 21601 UNITED STATES 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Armed Force þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 27 is marked other than "natural", traumatic event, the Medical Exa Specify: WHITE 3 X Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental ? ' is marked o ၉ WILLIAM GOODNESS CHARLOTTE POTTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health 2501 EAST PARRIS DR., WILMINGTON, DE 19808 MARJORIE JEAN ENGELHARDT/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of ONONDACAenVIAT ALVY place) 20c. Location - City or Town, State permit. Page 1 Department of i Important: If it 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CEMETERY 2010 SYRACUSE, NY FELLOWS HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 21. Signature of Funeral Se rgice Licensee 408 SOUTH LIBERTY STREET, CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Lour Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that the death certificate be executed Cause (Disease or finjury that initiated events sician and burial-tran Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Box 68760 attending IF FEMALE: Se 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy ō in the past 12 months? Month 5 Other (specify) Yes 2 □ No signed by the a d be detached f 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Division of Vital Records, Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 6 NOther 10 Hospital: 2 No ျ 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🚾 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nerse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar

JEVFFRON

31. Date filed (Month, Day, Year)

2540

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Physician/ october 7 10:50 AM JEAN BARBARA HADDAWAY Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death QUEEN ANNE'S CENTREVILLE CORSICA HILLS NURSING HOME If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** 1 🗆 M 2 🗶 F Hours Min APRIL Day Year 1916 PENNSYLVANIA Director 218-14-1087 94 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director GRASONVILLE MD OUEEN ANNE'S 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21638 4802 MAIN STREET 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Maryland 21215-0036 1 Yes 2 No Specify Specify: WHITE 3 X Widowed 4 □ Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ MARION CHARLES BADORSKY CECELIA BARACHKOWSKI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5428 SHADOWWOOD DRIVE, VIRGINIA BEACH, VA 23455 FRANK W. HADDADAY/ SON Department of Healt Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 🕱 Burial 2 🗆 Cremation 3 🗀 Removal from State OCT. 9, STEVENSVILLE CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MD 2010 permit. Signatura of Funeral Service Lice see 22. Name and Address of Fa FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, 23a. Part 1. Enter the disease, or complications, or heart failure. List only one ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ause on each line Immediate Cause (Final Pnysician disease or condition 20015 Medical resulting in death) Due to ( Examiner Supertially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events 10019 Examine Due to (or as a or Attending Physician: The law requires that the death certificate be executed burial-transit 10Rs the attending physician and hed for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FFMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death detached 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Completed 1 Yes 2 No 3 Probably page 2 should been 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy performed death? certificate 1 Yes 2 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work?
1 Yes To the Hospital or Attendi within 24 hours after death To the Funeral Director: A 2 Accident M 2 🗌 No Investigation completed filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

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State

Registrar

32. Registrar's Signature

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 6 2010 2010 Edward C. Hedges 5:30 p.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Tranquility at Fredericktowne Frederick Frederick Social Security Number 8. Date of Birth
(Month, Day, Yea
July 15, If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 1 M 2 - F 220-18-1579 84 1926 Maryland **Director** Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 Yes XX No 10g. Citizen of What Country? USA 10e. Street and Number 10f. Zip Code Funeral 6441 Jefferson Pike 21703 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 🟝 Yes 2 🗌 No 1944
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: white 3 Widowed 4 Divorced Completed 1946 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 丑 Construction Foreman C& P Telephone Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H 27 is marked of traumatic ever pe John Hedges Mary Blumenauer permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic o 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6441 Jefferson Pike, Frederick, Maryland 21703 Grace Hedges - wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State Stauffer Crematory 4 Donation 5 Other (Specify) 10-8-2010 Frederick, Maryland 21. Signature of Funeral Service bicensee 22. Name and Address of Facility Stauffer Funeral Home harow Game 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) CONGESTIVE HOWRT FAILURE 7 cme Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 2 0 N 1 ☐ Yes 2 ☐ No \_\_ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) examiner? 2 🗷 No Certificate: To 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Autural 5 Pending 1 Yes 2 Accident
3 Suicide
4 Homicide 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check the best of my knowledge, Certifying Nurse Practioner: 29b. Signature and title of co 29c. License number 29d. Date signed (Month, Day, Year) D 32171 10/8/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OTIVA · COUCH in ALKOPS VILLE 1 CHARD 328 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 00 Registrar Graffe Son.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 20<sup>Y</sup>IO 08:05 A CAROLYN DIANE HORTON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George's Clinton Southern Maryland Hospital Social Security Number . Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year, 13. 1 🗆 M 2 😿 Months 1944 Washington, DC Director 579-58-2967 66 June Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director District Heights Md Prince George's 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20747 USA 6912 Foster Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 K Married δ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private 12th Cosmetologist permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Lou Mount Eugene Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6912 Foster Street, District Heights, MD 20747 Harry L. Horton, Sr. - Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Fort Lincoln Cemetery 10/16/2010 Brentwood, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Johnson & Jenkins Funeral Home Signature Funer Service See 716 Kennedy Street, NW, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) ULMON Medical Due to (or as a consequence of) Examiner M40 C DIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit CORONARI that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 month Month Year Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by COPD 1 Yes 2 No 3 Probably 4 Yunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 2 1 No Yes 25. Was case referred to or dical Be 26. Place of Death (Check only one) examiner? Hospital 2 100 ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred iniury atural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

29a. Certifier

29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

010

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33574 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ HICKERSON 3:55A<sup>M</sup> Medical OCTOBER 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FORESTVILLE NURSING HOME PRINCE GEORGE'S FORESTVILLE 24 Hrs. Min. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 M 2 DX Months Davs Hours 70 423-52-7507 Director ALABAMA Usual Residence of Decedent 28a-f show 10a. State 10b. County traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits AT.A **ETOWAH GADSDEN** 1 X Yes 2 No ö 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 410 JOSEPH T. ROBINSON STREET 35901 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. ۾ 1 Never Married 2 Married and 2 should be filed within 72 hours after or Health and Mental Hygiene. Roke, Cornalimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed If Yes, Give Specify: BLACK 3 Widowed 4 Divorced Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOME MAKER PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JOHN THOMAS DUKES FLORA JEAN WADE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHIQUINA THOMPSON/GRANDDAUGHTER 8826 HUNTING LANE LAUREL, MARYLAND 20708 STROKe Baltimore, 1 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite 20c. Location - City or Town, State . Page 1 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OUANTICO NAT'L CEME. 10-21-2010 TRIANGLE, VIRGINIA 21. Signature of Juneral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. any W i 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 Part . Enter the disease, or cominications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sinck, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ STROKE disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** HYPERTENSION Sequentially list conditions, if any, leading to immediate outse. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) burial-trans Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 XNo
9 Unknown 5 Other (specify) Month Day Year P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an Hospital or Attending Physician: The law page 2 autopsy performed? Yes 2 X No 1 Yes 2 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No ဂ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5  $\square$  Pending after death. Director: Af Accident
Suicide Investigation 6 Could not be 1 ☐ Yes 2 ☐ No in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4  $\square$  Homicide determined City or Town, State) within 24 hours
To the Funeral Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 🎢 29c, License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

30. Name and address of person with completed cause of death (Item 23a) (Type, Print)

32. Regis

BAHRAM PISHDAD M.D.

31. Date filed (Month, Day

OCT 1

D 51520

1328 SOUTHERN AVENUE SUITE 310 WASHINGTON, DC 20032

10.12-2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Frances Kypfer Hummel 809 Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Western MD Regional Medical Center mperl a. 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9 Birthplace (State or Foreign **Funeral** Days Hours 0771671922 1 M 2 X F 458-22-2778 88 Texas Director Usual Residence of Decedent Hem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he norified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Cumberland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10 N. Liberty Street 21502 USA 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc Completed by 1 Never Married 2 Married 1 Yes Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ernest Kypfer Mueller Annie Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or nural nounce normal), 849 Braddock Road, Cumberland, Kery C. Hummel / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Dremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Cumberland Crematory: 10/12/2010 Cumberland, MD 22. Name and Address of Facility Adams Family Funeral Home, P.A. of Funeral Service Lice 404 Decatur Street, Cumberland, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arres shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ON GEST disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to for as a consequence of: signed by the attending physician and d be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year 1 ☐ Yes ∠ ∠ g ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe certificate Yes 2 2 🗌 No 1 🗌 Yes eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 🗆 Yes 2 A No Other: 1 Nnpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completed filled i Medical 29a Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature a 29d, Date signed (Month, Day, Year)

State Registrar

5

DOS

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alida Podrumar, M.D.,

31. Date filed (Month, Day, Year)

12

D006

5462

12502 Willowbrook Rd, Suite 300, Cumberland, MD

10/10/10

21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Pay 2010 Beverly Jean Huber October 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Loyalton at Hagerstown Washington County Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, NoV • 18 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral Hours 1 □ M 2 🗓 F Pennsylvania 196-14-2463 Director Nov. 84 Usual Residence of Decedent 23a or 28a-f show 10b. County 10c. City, Town or Location th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director Maryland Washington County Hagerstown 1 ☐ Yes 2X No 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 20009 Rosebank Wav 21740 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🗓 No 1 Yes 2 If Yes, Give Year or Dates. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other tha any injury or other traumatic conce. Board of Education Baker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Clement F. Bickley Mildred Smith Bickley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stacey S. Hornbecker-daughter 21908 Beaverbrook Dr. Smithsburg, MD 21783 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Cedar Lawn Mem. Park 10-14-2010 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern BLvd.North Hagerstown, MD 21742 23a. Part 1. Enter the disease, in conductions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ o diordial disease or condition resulting in death) 5-20 mm Medical Due to or as a consequence of) Examiner Sequentially list conditions, Examiner ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) Pregnant at time of death signed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💯 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has to the Funeral Director, After this certificate has to the funeral director, page 2 s performed? Yes 2 V No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 1 🗆 Yes 2 📭 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 NOther (Specify) ASSISTED LIVING 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗆 No 2 Accident
3 Suicide
4 Homicide Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🖰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 46561

06H-45

Box 68760

P.O.

Registrar DHMH 17 Rev 7/2009

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(WAI)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Simon

31. Date filed (Month, Day, Year,

10-07924 James Howard Pleas

se	Type or Print in Black Indelible link. Ensure All Copies Are Legible.	
	State of Maryland / Department of Health and Mental Hygiene	2

ames Howard	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar  Certificate of Death Reg. No.  20   0 3 3 5 7 7									
Physicia Medical Exami	ın/	1. Decedent's Name (First, Middle,Last)  JAMES HOWARD						2. Date of Dea Month October	Day Year 15, 2010	3. Time of Death 0751 hrs
		4a. Facility Name (if not institution, give st University Hospital	reet and number)	4	b. City, Tov Baltimo	vn, or Locatio ore	on of Death		4c. County of De	ORE CITY
Funeral Director		5. Social Security Number 6. Sex 220-62-9777	7. Age (In yrs. 2 55	last birthday) Yrs.	If Under Months	1 Year If Ur Days Hou	nder 24Hrs. urs Min.	8. Date of B	irth(MM/DD/YYYY) 9. 5, 1955	Birthplace (State or reign WASHINGION, Country) D.C.
any	F	Usual Residence of Decedent  10a. Stete 10b. County	10c. City	, Town or Locati	on				···	10d. Inside City Limits
<b>*</b> .	ō	MARYLAND CHARLES	IND	IAN HEA						1 X Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 4317 OLD INDIAN HEA	D HIGHWAY		10f. Zip C	ode 20640			10g. Citizen of What C UNITED STA	
15-0036 filed within 72 hours after death with the Maryland Hygiene. dother than "natural", or items 23a or 28a-f she i, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 Married	2. Was Decedent Ever in U Armed Forces?	If Ye	es, specify (	of Hispanic C Cuban, Mexic	an, Puerto F		White, etc	
urs after tural",	2	3 Widowed 4 Divorced If Nor 15. Decedent's Education (Specify only It	es, Give Year 1975—1977 Dates: nighest grade completed)	16a. Decedent	t's Usual Oc		ve kind of wo		Specify: B	
5-0036 led within 72 ho Hygiene. other than "na	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+) YEARS			ng life. DO NO		ed)	FOOD SEI	RVICE
C 2 2 2 3 E	Be	17. Father's Name (First, Middle, Last) EUGENE ROGER HOWARD				ROS	E CATH	IERINE	Maiden Surname)  DONIVER HO	
O & B : #	٩	19a. Informant's Name/Relationship (Type JUDY DONIVER / SIST							mber, City or Town, Si AN HEAD, I	tate, Zip Code) MARYLAND 20640
Gre, N ges I and 2 t of Health : If item 3		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  ST. CHARLES CEMETERY  OCT. 22, 2010 GLYMONT,								
Baltimore, MI permit. Pages I and 2.8 Department of Health a Important: If item 27 injury or other traum	118	Donation 5 Other Specify:  ina re of F ral Service Li  Donation 5 Other Specify:  22. Name and Address of Facility THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD								
Physician		23a. Part I. Enter the disease, or complica failure. List only one cause on each	tions that caused the death	. Do not enter th	ne mode of	dying, such as	s cardiac or	respiratory ar	rest, shock, or heart to Remote	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Head Tra	uma						Death
	ē	Sequentially list conditions, if any, leading to immediate b.	e to (or as a consequence o	of):		_				
d sit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e to (or as a consequence o	of):						
be executed sician and urial - transit	dical	d.  X UNPENDED X A	MENDED 23a,27, 28f pe	28a-f p	er "ne	, <u>g</u> 913	3-18-	ll vt		
18760, rtificate being physic as the bur	n/Mec	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of preg	gnancy	tal death		opic pregnan		23d. Date of deli Month	very Day Year
Division of Vital Records, P.O. Box 6876C tal or Attending Physician: The law requires that the death certificate I rs after death.  al Director: After this certificate has been signed by the attending physical in by the funeral director, page 2 should be detached for use as the bin by the funeral director, page 2 should be detached for use as the bin the funeral director, page 2 should be detached for use as the bin the funeral director.	ysician/Me	past 12 months?  1 Yes 2 No 9 Unknown	Pregnant at time of do		ner (Specify	n)				
that the detached	by Phy	Part II. Other significant conditions co	ntributing to death but not i	resulting in the u	nderlying ca	ause given in	Part I.			to the cause of death?
ords, F w requires t is been sign should be	eted							24a. Was	s an   24b. Were	autopsy findings available to completion of cause of
ecor he law 1 ate has b	Completed						***		ormed? death 2 No 1	1?
Vital Rec ysician: The his certificate director, page	Bec	25. Was case referred to medical examiner?	nital:	7		Place of Dea			] o[]o	
n of Virding Physical After this funeral directions	ပ	1 ✓ Yes 2 No  27. Manner of Death	pital: 1 ✓ Inpatient 2 ☐	ER/Outpatient 28b. Time of Ir		c. Injury at W	ork?	28d. Describe	how injury occurred	ther:
ivision Control of Attending after death.  Director: After In by the fun	Certification:	1 Natural 5 Pending Investigation 2 Accident 2 Accident 2 Replace of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 2 Replace of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 2 Replace of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 2 Replace of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 2 Replace of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 2 Replace of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 2 Replace of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 2 Replace of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 2 Replace of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 2 Replace of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 2 Replace of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 2 Replace of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 2 Replace of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 2 Replace of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 2 Replace of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 2 Replace of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 2 Replace of Injury - At home, farm, street, factory, etc.)								
Divis pital or A ours after neral Dire	ertific	3 Suicide 6 Could not be determined	(Specify) road		et, factory, o	ffice building,	, etc.	or Town.  Dall		Rural Route Number, City
the Hos hin 24 h the Fur npletely	Medical C	29a. Certifier 1 Certifying Physician: (Check only one) 2 Medical Examiner: One	To the best of my knowled the basis of examination and dimanner stated.							
To witi	Re	29b. Signature and title of certifier				icense numb	per		29d. Date signed (	
		30. Name and address of person who com	pleted cause of death (Iter	m 23a)	`				1	
281		Melissa Brassell, MD Assi	stant Medical Exami	ner 111 P		et, Baltime	ore, MD 2	21201		
St Regist	ate trar	31. Date filed (Month, Day, Year)  OCT 2 ( 2010	32 Registrar's Signat	I. par	Kel					

DOME

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 2010 8:58 AMM q THERESA DAWN JOHNSON Oct 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Talbot Genesis HealthCare -The Pines Easton Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) Months Days Hours Min. 1 □ M 2 T F 03/29/1967 220-96-1662 **MARYLAND** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City Town or Location 10a State 1 ☐ Yes 2√ No **MARYLAND** DORCHESTER **CAMBRIDGE** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2136 HUDSON RD 21613 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 | Yes 2 No If Yes, Give Year or Dates: 1 ☐Yes ≱ No Specify Specify: 3 Widowed 4 Divorced WHITE 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CAFETERIA COOK **EDUCATION** 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) GORMAN MYLES LANKFORD, SR RAMONA ABBOTT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THOMAS R. JOHNSON, JR. / HUSBAND 2136 HUDSON RD., CAMBRIDGE, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 10/11/2010 4 Donation 5 Dother (Specify) CAMBRIDGE, MD MID SHORE CREMATION CENTER 21. Signature of Funeral Se 22. Name and Address of Facility CURRAN-BROMWELL FUNERAL HOME, P.A., 308 HIGH ST., CAMBRIDGE, MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neno carcinoma 10613 Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy ☐ Live birth 2☐ Fetal death ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? gnificant conditions contributing to death but not resulting in the underlying cause given in Part I. pulmonar 1XYes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □ No autopsy performed? Yes 20 No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of eath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No

law requires that the death certificate be executed and Box 68760, attending physician Division of Vital Records, P.O. the peen has Hospital or Attending Physician: The certificate this After death.

burial-tran the SS use a ģ signed by the page 2 24 hours after death Funeral Director:

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

\$

Completed

Be

Certification: To

Medical

2 Accident

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

3 Suicide

29a. Certifier

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Expending must be notified at

12 should be file. It and Mental H

permit. Pages 1 and 2 s Department of Health ar Important; If item 27 Is any Injury or other trau

Physician

/Medical

Examiner

a Johnson Maryland 21215-0036

Baltimore,

within 2

Registrar

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be determined

(ROWLE 010 31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33579 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician JOHNS charc OCTOBER 2010 1036 M lames Jr. 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** EASTON MEMORIAL HOSPITAL TALBOT If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 M 2 □ F Dec. 18,1947 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show 1 Wes 2 No rappe Directo albot with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral Over Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 21215-0036 1 Never Married 2 Married 1 ☐Yes 2 PNo ģ Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seafood Industr perator 7 is marked other traumatic event, II Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ Johns 2: Brooks Ma e 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a important: if item 27 is any injury or other trai once. Trappe Mary/and 2/673 Lane overs 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State 10/14 TOWN CEMEtery 4 ☐ Donation 5 ☐ Other (Specify) Easton, Maryland 22. Name and Address of Facility 21. Signature of Funeral Şervice Licenses Henry Funeral Home, P.A. 510 washington st. Cambridge MD 21613 23a. Part Enter the disease, or complications that caused the de the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as a rdiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Te /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. ned by the attending physician detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year ☐ Pregnant at time of death 5 Other (specify) 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar

29b. Signature and title of certific

31. Date filed (Month, Day, Year)

Navmits

ZVyene

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Ponhester

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33580 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** 240 M Vesler 2010 Ohn /Medical %. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number 4c. County of Death Examiner ambridge Dorchester Dorchester HOSP, tal General If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Months Yrs. Dec. 216-12-123 Director Maryland Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Ves 2 No 7 is marked other than "natural", or items 23a or 28a-f si traumatic event, in Medical Examination until be notified Director Dorchester 10g. Citizen of What Country? 10e. Street and Number Street 21613 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 21215-0036 1 ☐Yes 2 No 3 ₩Widowed 4 □ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Mechanic Trucking Compan Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Jolley ပ္ Kosie Ward permit. Pages 1 and 2 shoul Department of Health and Mi Important: If item 27 is mark any Injury or other traumati 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Cambridge MD. 21613 4nnie Mae 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 10/11/10 Taylors Island, MD. NewRevived Church Cent. 4 Donation 5 DOther (Specify) 22. Name and Address of Facility Henry Funeral Home, P. A. 21. Signature of Funeral Service Licenses 23a. Party: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate support of the disease of the death of the de Immediate Cause (Final Sephi SLOCK **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner piraha Vazunavia Sequentially list conditions Examiner any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last blocia law requires that the death certificate be executed Amoverhicala tin Algree

Due to (or as a consequence of) 11.72 and burial-tran P.O. Box 68760, attending physician Physician/Medical as use a IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate of Vital 1 □Yes 2 -No 1 ☐ Yes 2 No Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1-Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 10.4.10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

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32. Registrar's Signature

THANWY

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Leithead Jackson October 2010 0623 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Casey House Rockville 8. Date of Birth (Month, Day, April 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex Funeral Months Days Hours 1 **X** M 2 □ F 1958 Pennsylvania Director 52 213-82-9579 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

The first of the first er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County Directo 1 X Yes 2 No Hagerstown Washington MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral U.S.A. 21740 717 Medway Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give 1 ☐ Yes 2X☐ No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Retail Associate Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nellie Shoemaker William M. Jackson, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 245 Wildwood Dr. Apt.79, St. Augustine, FL Jeanne J. Moeller/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Lawn Mem. Park 10/13/2010 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, MD Rest Haven Funeral Chapel 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death months Immediate Cause (Final Physician/ Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live Birth 2 - Fetal death in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death Yes 2 No 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Schizophrenia 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform this certificate has death? 2 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 1 ☐ Yes 2 💢 No 1 Inpatient 2 ER/Outpatient 3 IDOA ည Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 🗌 Yes 2 🗀 No Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 🗀 only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b, Signature and title of certifier 37142 10-10-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SH-1 1355 Piccard Dr., Rockville, MD 20850 Coleman

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Richard Lee Kendall October 12, 2010 12:15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frostburg Village Nursing Home Frostburg Allegany 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 € M 2 □ F 64 218-48-9125 Director 07/14/1946 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Examinations must be redited at once. once. 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 X Yes 2 ☐ No Funeral Director MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 217 Arch Street USA 21502 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Bakerv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kendall Booth Allen Agnes Christiana ပ pajwami's Name/Relationship (Type. Print)
Betty Kendall / Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 217 Arch Street, Cumberland, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory 10/13/2010 Cumberland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, and the line in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1 □ Yes 2 N/No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 DNursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 21⊠No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of De th 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natura! 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCTOBER 12 2010 126907 Hallow 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) noss 925 Bishop Walsh Road, Cumberland, MD Harjit S. Sidhu, M.D., 31. Date filed (Month, Day, Year) 32. Registrar's Signature OCT 13 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Potembe 041 Lula May King Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington County Hospital Hagerstown Washington 7. Age (In yrs. last birthday) Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 220-16-3102 Hours Min Director Usual Residence of Decedent show 10a. State 10h County er than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Washington Smithsburg 1 🗆 Yes 2X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17 Blue Mountain Estates U.S.A. 21783 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Armed Forces? Black, White, etc ģ 1 Never Married 2 Married Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done duning most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. 7 is marked other than "1 residence Elementary/Seconday (0-12) College (1-4 or 5+) homemaker 12th grade Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Alta May Mills permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or and ည Samuel Sherman McCarthy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1801 Mayflower Circle Lancaster, PA 17603 granddaughter Terri King Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Oct.Date2 20c. Location - City or Town, State Marial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Clear Spring, MD St. Paul Cemetery 2010 . Signature of Funeral Service Donald Edwin Thompson Funeral Home, Inc P.O.BOX 310 Clear Spring, MD 21722 aki CERTIFICATION OF PROPERTY OF MEDICAL ELAWINES 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition W Medical resulting in death) Examiner TW Sequentially list conditions, Examiner If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the bunal-transit attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
. 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Live Birth 2 L. Fetal deat
Pregnant at time of death
Unknown in the past 12 months? Day Yes 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an eral Director: After this certificate has filled in by the funeral director, page 2 s autonsy performed Yes 2 1 Yes 2 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examine? Hospital: 2 🗌 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 8/22/2010 Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred ☐ Natural Accident injury work? 5 Pending 22/2010 unknow1M Investigation Could not be 28f. Location (Street and Number or Rural Route Number, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide determined tome Mountain Esta within 24 hours a MO Medical 20a Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 09-29-2010 . Name and address of person who completed cause of death (Item 23a) (Type, Print) 00H-6 seem Mr. 31. Date filed (Month, Day, State OCT 13 Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For ■ State Registrar	State of Mar		epartment of H C <i>ertificate of D</i>			giene Reg. N	ZU1U	33584
			Decedent's Name (First, Middle, Las	*)				2. Date of De	ath		3. Time of Death
	Physicia Medic		Barbara Faye Knol					10710/	2010	ay Year	11:20 A M
	Examin	er	4a. Facility Name (if not institution, give	ŕ		4b. City, Town, or				County of Death	
	Funeral		14 30th St. unit 5. Social Security Number 6. Se		n yrs. last birthe	Ocean Ci	If Under 24 Hrs.	8. Date of Bir		orcester	pplace (State or Foreign
	Director		579-48-2436 Usual Residence of Decedent	□ M 2 <b>X</b> F 77		rs. Months Days	Hours Min.	5/2017 T		Wash.	ntry DC
	and show	or	10a. State 10b. County	1	0c. City, Town	or Location					10d. Inside City Limits
	Maryla 28a-f	rect	MD Worcester	0	cean Ci	ty					1 😾 Yes 2 □ No
	h the ka or 2 be no	al Di	10e. Street and Number	•		10f. Zip Code			•	itizen of What Cou	untry?
	ith wit ms 23 must	Funeral Director	14 30th St.	12. Was Decedent Eve	i 11 C	21842	i- Ori-i-2 (Co.		USA		
0	er dea or ite niner	by Fu	11. Marital Status  1  Never Married 2  Married	Armed Forces?		<ol> <li>Was Decedent of His If Yes, specify Cubar</li> </ol>	n, Mexican, Puerto	Rican, etc.)		14. Race - Ameri Black, White,	
3	ırs aftı ural", IExal		3X Widowed 4 □ Divorced	If Yes, Give Year or Dates.		1 ☐ Yes 2x☐ No	Specify:			Specify: whit	e
<u>2</u>	72 hou	plet	15. Decedent's Ed (Specify only highest gra		1 (	Decedent's Usual Occupa Give kind of work done d	ation uring most of work	ing	16b. l	Kind of Business In	ndustry
717	/ithin iene. r thar the M	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+)	1	fe. DO NOT use retired) nemaker			sel	Lf	
g	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden	Surname)	
<u>Xa</u>	ld be Menta larked atic e	욘	Benjamin F. Butl	er			Mertice	Travis			
Maryland 21215-0036	2 shou h and 7 is m traum		19a. Informant's Name/Relationship (Ty			Mailing Address (Street a					Code)
رة _	and 2 Healt tem 2		Teri Tomlin (daug	hter)		3 Ridge Dr. Disposition (Name of	-	a, MD Z		ocation - City or I	Town State
ē	Page 1		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)		cemetery	crematory or other place enlopen Crem	9)			nkford DI	
Baitimore,	permit. Page 1 and 2 should be filed Department of Health and Mental Hi Important: If item 27 is marked otl any injury or other traumatic even once.		21. Signature of Funeral Service Ligens		<u>-</u>	22. Name and Addres	s of Facility The	Burbag	e Fı	neral Ho	
_	HD = # 0	Н	23a. Part 1. The the disease, or comp	7_SOL lications that caused th	ne death. Do no	108 Willia		•		1011	Approximate
2.0	Trysician/		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	1.00	Amest	,,	, , , , , , , , , , , , , , , , , , ,	, , ,		Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)	a. Due to (or as a c							
		ē	Sequentially list conditions,	b. Due to lor as a c		k.					
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	HTM	/						
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or as a c	onsequence of	):					
3	physic physic the b	edical		d							
8	certific	III/III	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		0 - 5-1			Į	23d. Date of deli	very
рох ра	death he atte ied for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live Birth 2 4 Pregnant at ti 9 Unknown		3 ☐ Ectopic pregnanc 5 ☐ Other (specify)	у			Month	Day Year
л Э	nat the ed by t detach	/ Ph	Part II. Other significant conditions of	ntributing to death but	not resulting in	the underlying cause giv	en in Part I.	23e. Did t	obacco	use contribute to	the cause of death?
s,	n signe	ed by	M.S.					1 🗆	Yes 2	2 ∕No 3 □ Pro	obably 4 🗌 Unknown
Š	tw requires bee	Completed						24a. Was			opsy findings available ompletion of cause of
ě	The Is	Con						perfo	ormed?	_ death?	2 🗆 No
<u>a</u>	sician: certific rector,	Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:		Othe	ace of Death (Chec	_			
7	Phys or this eral di	e: 10	27. Manner of Death	28a. Date of injury	28b. Ti	me of 28c. Injury	4 L Nursing Ho	ome 5 Resi 28d. Describe I		6 Other (Special	fy)
ono	anding sath. rr: Afte	ficat	Natural 5 Pending 2 Accident Investigation		<i>(ear)</i> inj	ury work	? Yes 2□No			.,	
Division of Vital Records,	I or Atte after de Directo	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (	- At home, farr Spec <i>ify)</i>	n, street, factory, office		28f. Location ( City or Tox		nd Number or Run e)	al Route Number,
_	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 L Medical Exami	ner: On the basis of exar	mination and/or	eath occured at the time, investigation, in my opinio dge, death occurred at the	n, death occurred a	t the time, date :	and plac	e, and due to the c	ause(s) and manner stated.
_	To th withir To th comp	~	29b. Signature and title of certifier			29c. License	number	,		ate signed (Month,	
			20 Name and a filtrary of	ampleted source of door			5870/		- (	10/12/1	U
J	TN 5		30. Name and address of person who o								
	Stat Registra		31. Date filed (Month, Oey, Year)	32. Registrar's	Signature					-	
			UV-1-1-2-2	UIU Thresen	4 1	Braket.					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 1015AM October 2010 06 George Lewis David /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Dorcheste b nida aeneral tosprta Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. ast birthday) **Funeral** <sup>Year)</sup> 4 1937 Months Days 1 🛣 M 2 🗆 F Sept. 215-36-1479 73 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County death with the Marylan If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Exemiter must be rollfied at 1 ☐ Yes 2 ☑ No **Funeral Director** Dorchester Cambridge 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 5420 Skipjack Drive 21613 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Black White etc and 2 should be filed within 72 hours after ealth and Mental Hygiene. • 27 is marked other than "natural", or iten 1 ☐ Never Married 2 🙀 Married white 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) custodian public school 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alma Marie Richardson Russell Lewis ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife 5420 Skipjack Drive, Cambridge, MD Beatrice Lewis 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 a
Department of He
Important: If item
any injury or oth
once. 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/9/10 4 ☐ Donation 5 ☐ Other (Specify) Dorchester Mem. Park Cambridge, MD 21. Signature of Huneral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. A ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final accident **Physician** erebrovasavar mohute disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner pertension Sequentially list conditions, it only in a line of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transi cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) 1 □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed' 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year) OCT 12 2010

Malkers,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

408 Byon 32 Registrar's Signature

29d. Date signed (Month, Day, Year)

October 8, 2010

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Lemmon 2010 Thelma E. October 6

11:00 AM

Physician/ Medical Examiner

= State Registrar

28a-f shov ral", or items 23a or 28a-f sho Examiner must be notified at within 72 hours after death with the Maryland "natural", injury or other traumatic event, the Medical than ould be filed withind Mental Hygiene marked other th permit. Page 1 and 2 should be Department of Health and Mer Important: If Item 27 is marke any injury or other traumatic

Baltimore, Maryland 21215-0036

Physician/ Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi been signed by the should be detached cate has it After this certificate funeral director, pag I Director: A d in by the f within 24 hours after de To the Funeral Directo completed filled in by the

Division of Vital Records, P.O. Box 68760

4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick 105 Sandstone Drive, Apt. #302 Walkersville 8. Date of Birth Jan. 4, 1928 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Days Hours Mary land Director 216-24-0604 82 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Frederick Maryland Walkersville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21793 United States 105 Sandstone Drive, Apartment #302 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 XNo Specify: If Yes, Give Specify: Completed 3 XWidowed 4 Divorced White Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 George Strobel Sr. Mary Eidenbach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2701 Monocacy Ford Rd., Frederick, MD 21701 Mary Goldstein / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Stauffer Crematory 10/8/2010 Frederick, Maryland 4 Donation 5 Other (Specify) 21. Signal re of Funeral Service Licenses Stauffer Funeral Home 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part J. Enter the disease, or complications that saused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Onset and Death Immediate Cause (Final Atherosclerat disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Other (specify) Dav Year g | Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed Yes 2 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 131058 10-8-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gene Ashe MD, 10200 Coppermine Rd., Woodsboro, MD 21798 31. Date filed (Month, Day, Year, 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month October 08, 2010 Physician/ Vicki A. Linn 05:05 AM M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Allegany County Nursing & Rehab Cumberland If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) November 24. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 212-38-5052 70 Director Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 □ No Maryland Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 401 Grandview Drive Funeral 21532-U.S.A permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 Yo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗹 No Specify. If Yes, Give Specify: 3 Divorced Completed White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George G. Kennedy Sarah Edith Menear 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) David M. Linn Sr. Husband 21532-401 Grandview Drive Frostburg Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory Cumberland October 11, 2010 21. Signature of Funeral Service License 22, Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ninumu Medical Due to (or as a consequence of): Examiner unionani Sequentially list conditions. If any, leading to in mediate cause. Enter Underlying Cause (Disease or injury Due to for as a consecuence of Exami the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last nding physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 N certificate has been signed by the a rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ 100 funeral director, Be 26. Place of Death (Check only one) Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ■ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner eath 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: atural 5 Pending 1 Yes 2 🗌 No 24 hours after death. Funeral Director: A Accident Suicide Investigation within 24 hours after death

To the Funeral Director:

completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier 29c. License number ٥ Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

32. Registrar's signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death October 14, 2010 Year 01:25 AM M Physician/ Geraldine Gertrude Lewis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Allegany Moran Manor Health Care Center Westernport If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🗹 F September 08, 1918 Maryland 92 220-10-0203 Director Usual Residence of Decedent 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director Westernport 1 🗌 Yes 2 🗷 No Allegany Maryland 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 23826 Stoney Run Road, S.W. Funeral U.S.A. 21562-2120 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 31 and 2 should re filed within 72 hours and of Health and Mental Hygiene.
If item 27 is marked other than "natural". "natural", 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) textile manufacturing Conning department Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maggie Warnick Benjamin Wilt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) Maryland 21562-23826 Stoney Run Road Westerport daughter Connie Martin 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date permit. Page 1 a
Department of H
Important: If ite emetery, crematory or other place Cumberland Crematory 1 Burial 2 S Cremation 3 Removal from State injury or Cumberland, Maryland October 14, 2010 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Tuneral Service Licensee any Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Co nonavy Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and -tran Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death ed by the a detached f g Unknown as been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 ☐ No 3 ☐ Probably 4 → Ghknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy 1 ☐ Yes 2 ☐ No After this certificate Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be funeral director, Other: 4 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Natural 5  $\square$  Pending 1 ☐ Yes 2 ☐ No death. 2 Accident
3 Suicide Investigation within 24 hours after death

To the Funeral Director: / 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c, License number 021284 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jesus Tan, 4 Broadway St, Frostburg, MD 21532

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State Registrar 32. Registrar's Signature

For Amended #17 per State of Maryland / Department of Health and Mental Hygiene 2 0 state Amended #26 per MD, RG FCHD 10/08/10 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 26 Physician/ Morrison, Month James Jr. September 10:30 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3348 Basford road Frederick Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 15, 1930 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🖁 M 2 🗆 F Months Days Hours Min. 220-28-7065 Mary Land Director 79 Yrs Usual Residence of Decedent shov 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 No Maryland Frederick Frederick 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? pe 23a Funeral 3348 Basford Road must 21703 United States filed within 72 hours after death val Hygiene. Jother than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Examiner Black. White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Wivorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Electronic other traumatic event, Be 17. Father's Name (First, Middle Mostrison 18. Mother's Name (First, Middle, Maiden Surname) and Mental h မ should be Granville Morrism, Sr. Laura White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Dan Morrison / Son 3348 Basford Road, Frederick, MD 21703 20a Method of Disposition 20b. Place of Disposition (Name of Page 1 a 20c. Location - City or Town, State Date Important: If it any injury or o cemetery, crematory or other place)
Stauffer Crematory 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/29/2010 Frederick, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home outre 1621 Opossumtown Pike, Frederick, MD 21702 23a. For Enter the dilease, or complications that have used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ROGRESSIVE SUPRANUCLEAR Medical Due to (or as a consequence of) Examiner EMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Exami -tran Due to (or as a consequence of): attending physician for use as the burial Physician/Medical that the death certificate be Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Day Year Pregnant at time of death 9 Unknown P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed? certificate 2 🗆 No Yes 2 No 1 Yes **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After Hospital or Attending work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: After completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Bethlyomp 00065201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FITTEBERG, CRESTWOOD BLUD FREDERICK no 32. Registrar's Signature 7190 31. Date filed (Month, Day, Year) State Cleveran Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33590 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 201<sup>o</sup> 10:05 A™ Thomas J. McCormac, Jr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Worcester Atlantic General Hospital Berlin Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F Months Days Hours Min. 1277274 943 Director 66 PA 192-34-3506 Usual Residence of Decedent 10c. City, Town or Location must be notified at 10d. Inside City Limits **Funeral Director** 28a-f 1 Yes 2x No MD Worcester Berlin 10e. Street and Number 10f. Zip Code 6 10g, Citizen of What Country? 23a USA 21811 52 Boston Dr. Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No 1 ☐ Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Comm of PA Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Helen C. Fee 006, 12/12/43 Thomas J. McCormac, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 52 Boston Dr., Berlin, MD 21811 Grace E. McCormac / wife Baltimore, 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Resurrection Cemetery 10/13/2010 Harrisburg, PA 21. Signal of Funeral Service licensee Burbage Funeral Home 22. Name and Address of Facility Berlin, MD 21811 William St., Pag 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) THENOSCEROTIC AS01450 Medical Due to (or as a consequence of) Examiner MOZUNS Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury 1 PERTENSION ed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical TUPERLIPIDEMIA IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Year Pregnant at time of death Yes 2 No 1 Yes 2 9 Unknown 9 Unknown is certificate has been signed by director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performe Hospital or Attending Physician: The l 24 hours after death.
 Funeral Director: After this certificate h Yes 2 XN 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Cornac, Thouas Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certificate: To 1 Inpatient 2 KER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 title of certifier Signature a 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10324 000 OCEMN CITEBUND. BESTELD, MD218/1 DA1 15 CASTANEDA MO 31. Date filed (Month, Day, Year) State **act 08** Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Rose Marie Martirano 6 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death . County of Death **Allegany** Examiner Western Maryland Regional Medical Center Cumberland Social Security Numbe If Under 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F 68 Months Days Hours Min (Month May 01, 1942 De try) 220-40-2211 **Director** Usual Residence of Deceden or 28a-f show 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Allegany Frostburg 1 X Yes 2 No 10e, Street and Number 341 Grand View Drive 10g. Citizen of What Country? U.S.A. 10f, Zip Code Funeral 21532-12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married þ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗭 No Specify: White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) nomemaker homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ unknown unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
341 Grand View Drive Frostburg Maryland 19a. Informant's Name/Relationship (Type, Print) 21532-Frostburg Carl Martirano husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Frostourg Memorial Park Cumberland Maryland 10/15/10 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee 21. Signature Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 Phole. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last the burial-transi and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Year Month Day be detached signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 24 hours after death. e Funeral Director; After this certificate 2 No Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ျှ 1 X Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work?
1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier son who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State

Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland /			ental Hygi	ene	0 00500
		1 — State Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of I			g. No.	U 33592
Physici	an/				2. Date of Death Month	Day Year	
Medi Exami		George Charles Meyer, Sr.  4a. Facility Name (if not institution, give street and number)	4b. City. Town, o	r Location of Death	October	8 2010 4c. County of De	1/0/0
LAGIIII	ilei	311 Sunbrook Lane	Hagers				on County
Funera	Г	5. Social Security Number 6. Sex 7. Age (In yrs. last bird	thday) If Under 1 Year	7	8. Date of Birth	9. B	irthplace (State or Foreign
Director		102-26-0007	Yrs.		Dec. 14	,1933 Ne	w York
and show	5	10a. State 10b. County 10c. City, Tow	n or Location			·	10d. Inside City Limits
Maryla 28a-f	rec	Maryland   Washington County   Hagers	stown				1X Yes 2 □ No
n the		10e. Street and Number	10f. Zip Code		11	0g. Citizen of What (	Country?
th with ms 23 must	Funeral Director	311 Sunbrook Lane	21742			U.S.A.	
r dear		11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spec an, Mexican, Puerto R	ity Yes or No- ican, etc.)	14. Race - Am Black, Wh	
O3C	l pa	3 ☒ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2X No	Specify:		Specify: Wh	ite
Maryland 21215-0036 2 should be filed within 72 hours after death with the Maryland lith and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	Completed by	15. Decedent's Education (Specify only highest grade completed)	. Decedent's Usual Occup (Give kind of work done			16b. Kind of Busines	s Industry
thin 7	Į Ę	Elementary/Seconday (0-12) College (1-4 or 5+)	life. DO NOT use retired)		·	Federal G	overnment.
d 2 ed wij Hygie other	Be	17. Father's Name (First, Middle, Last)	alth Physici	18. Mother's Name			3 ( 32 ( 11 ( 11 ) )
lan be fil ental rked ic ev	10	George Lawrence Meyer		Marie N	,	,	
faryl should and Me is mar			o. Mailing Address (Street				Zip Code)
			11 Sunbrook	Lane Hage			
- 5 E O		1 🗆 Burial 2 🕅 Cremation 3 🗆 Removal from State	of Disposition (Name of ery, crematory or other place	ce)		20c. Location - City of	I
Baltimore,  bermit. Page 1 and Department of Heal Important: If item: any injury or other pnee.		4 Donation 5 Other (Specify) Smith	sburg Cremat				
Baltimo permit. Page Department ( Important: Il any Injury or		21. Signature of Funeral Service Licensee		ess of Facility Doug		-	
		23a. Part 1. Enter the disease, or complications that caused the death. Do					Approximate
- Ph sician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	wang	FIBNUS			Interval Between Onset and Death
Medica Examine	1	resulting in death)  a. Due to (or as a consequence		( , , , , , ,	. ,		
Examine		Sequentially list conditions, b.					
ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	JJ,				
xecut n and al-trar	Exa	that initiated events resulting in death) Last C. Due to (or as a consequence	of):	· · · · · · · · · · · · · · · · · · ·			
68760 certificate be executed nding physician and use as the burial-transit	dical	d	. <u></u>				
6876 ertificat ding ph	Ğ	IF FEMALE:					-
th cer ttendi	ian/	23b. Was decedent pregnant 1 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal deat		су		23d. Date of o	delivery Day Year
ords, P.O. Box 687 requires that the death certifical been signed by the attending positional be detached for use as t	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death	5 Other (specify)				
P.O. that the ned by the detach	by Ph	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause gi	iven in Part I.	23e. Did tob	acco use contribute	to the cause of death?
rds, requires to been signatured be					1 □ Ye	s 2 🖪 No 3 🗆	Probably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requires is after death.  In Director After this certificate has been signed in by the funeral director, page 2 should be done by the funeral director, page 2 should be death.	Completed				24a. Was an		autopsy findings available o completion of cause of
Rec The la	l E				perform 1 Tyes 2	ned? death?	
tal cian: ertific	Be (	25. Was case referred to modical examiner?		lace of Death (Check of	only one)		
Physi Physi this c	은	1 Inpatient 2 ER/O	utpatient 3 DOA Oth	4 □ Nursing Hom		nce 6 Other (Spe w injury occurred	ecify)
on on or	cate		injury wor	k? Yes 2 \Bo	bu. Describe not	w injury occurred	
Jivision of Vital I or Attending Physician: after death. Director: After this certific I in by the funeral director,	Certificate:	3 Suicide 6 Could not be 28e. Place of Injury - At home, fa	arm, street, factory, office	2		eet and Number or F	Rural Route Number,
Div talor is after al Dir led in		building, etc. (Specify)			City or Town,	State)	
Division of Vital Recc To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director After this certificate has completed filled in by the funeral director, page 2.	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/o	or investigation, in my opini	on, death occurred at t	he time, date and	d place, and due to the	e cause(s) and manner stated.
<b>To the</b> I within 2 <b>To the I</b> comple	Ž	only one) 3 Certifying Nurse Practioner: To the best of my know 29b. Signature and title of certifier	vledge, death occurred at the			cause(s) and manner and Date signed (Mor	
F > F &		Karen in Hundeman		9444		1 1	2010
		30. Name and address of person who completed cause of death (Item 23a)	V.0)		,	- 1 111	
WH-14			10. 637	hours J	dusa	Drue c	tredonleho
Sta Regist		31. Date filed (Month, Day, Year)  OCT 1 4 2000  32. Registrar's Signature	-				
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Alice J Melson

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			For State of Ma	aryland / Depa					0 00000
			Registrar	Cei	rtificate of De			eg. No 2010	
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				<ol><li>Date of Death Month</li></ol>	n Day Year	3. Time of Death
	Medic	al	Alice Virginia Melson				10	09 2010	
	Examin	er	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Lo			4c. County of De	
5,2,10	-		5. Social Security Number 6. Sex 7. Age	e (In yrs. last birthday)	Salisbu	f Under 24 Hrs.	O Data of Digital	Wicom	ico
	Funeral Director		220-32-2005	74 Yrs.		Hours Min	8. Date of Birth $Month$ , Day, $13/19$	Year) 9. E	Birthplace (State or Foreign Country)  MD
			Usual Residence of Decedent	, ,			7/13/19.	,	TID
	sho d at	tor	10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary 28a-f otifie	Director	MD Worcester	Berlin					1 ☐ Yes 2 🛣 No
	a or be n	교	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What	Country?
	h witi nust	Funeral	10045 Old Ocean City Blv	d.	21811			USA	
	deat riten ner r		11. Marital Status 12. Was Decedent E Armed Forces?		Was Decedent of Hispa If Yes, specify Cuban, I	anic Origin? (Speci Mexican, Puerto Ri	fy Yes or No- ican, etc.)	14. Race - Ar Black, Wh	merican Indian,
5	after	d by	1 Never Married 2 X Married 1 Yes 2 X If Yes, Give	No .	1 ☐ Yes 2 🔀 No	Specify:			white
3	atura cal E	Completed	3 Uvidowed 4 Divorced Year or Dates.	16a Decer	dent's Usual Occupation	n n			
ς: :	72 h	ם	(Specify only highest grade completed)	(Give	kind of work done duri O NOT use retired)		7	16b. Kind of Busines	ss industry
9500-61212	withir giene er the		Elementary/Seconday (0-12) College (1-4 or 5		autician			Cosmetol	ogy
p	be filed within 72 hours after death with the Maryland ental Hygiene. Ked other than "hatural", or items 23a or 28a-f show ked other than "hatural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)			8. Mother's Name	First, Middle, M		
<u> a</u>	d be Menta	욘	Howard Jarmon			Viola I	Rogers		
Maryland	should be file n and Mental 7 is marked o raumatic eve		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and	l Number or Rural i	Route Number, (	City or Town, State, .	Zip Code)
e, ≥	nd 2 sealth m 27 ner tr		J. Marshall Melson / hus	sband 100	45 01d Oce	an City 1	Blvd., 1	Berlin, M	D 21811
ore	age 1 and 2 should be out of Health and Ment: it: If item 27 is marked y or other traumatic e		20a. Method of Disposition 1 □xBurial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispo cemetery, cren	osition (Name of matory or other place)	Da	ite :	20c. Location - City	or Town, State
Ē	. Pag tment tant: jury o		4 ☐ Donation 5 ☐ Other (Specify)	Evergreen		10/13	/2010 ]	Berlin, M	D
baitimor	permit. Page 1 a Department of I Important: If its any injury or of		21. Signature of Fungfal Service Licensee		2. Name and Address of			ineral Ho	me
	40 = 6 G		J. Juck Butage		108 Willia				
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line						
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F	hysician/ Medical	n i		<del>).</del>					
, J	hysician/ Medical Examiner			want Ca					Interval Between
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п	Physicia			e (First, Middle, Las						2. Date of D	eath 10	/6/20 <u>10</u>	3. Time of Death
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pro and	Examir	er	1	, 0	nal Medica	1 Con	tor	4b. City, Town, Salis		eath	40	c. County of Dea Wicom	
	Funeral		5. Social Security N	umber 6. S	ex 7. Ag	e (In yrs. las		If Under 1 Year Months Days	If Under 24			g. Bir	thplace (State or Foreign
	Director		115-28-03 Usual Residence of	4.3	□ M 2 🛣 F	73	Yrs.	Months Days	Hours	4/26/1	937		PA PA
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatte event, the Medical Examiner must be notified at ance.	ctor	10a. State	10b. County		10c. City,	Town or Lo	ocation					10d. Inside City Limits
	ne Mar or 28a notifi	Dire	MD 10e, Street and Nu	Worces	ster	Ве	rlin	10f, Zip Code			1 40 0	(14)	1 Yes 2 XNo
	with the 23a c	eral		atham Ct.				21811			Tug. C	itizen of What Co	ountry?
	death items her mi	F	11. Marital Status		12. Was Decedent   Armed Forces?	Ever in U.S.	13.	+	dispanic Origin's	? (Specify Yes or No	)-	14. Race - Ame	
336	al", or	Completed by Funeral Director	1 Never Man	ied 2 Married 4 Divorced	1 Yes 2 X If Yes, Give Year or Dates.	No		1 Yes 2 X N		derio Filodii, 6tc.,		Black, Whit	hite
2-0	hours natur dical I	olete		15. Decedent's E	ducation			dent's Usual Occu			16b. l	Kind of Business	
21215-0036	thin 72 ane. than '	mo	Elementary/Sec		College (1-4 or	5+)	life. D	kind of work done O NOT use retired	auring most or )	working			
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/an	d be fill dental rrked tic ev	ျ		on B. Kii	<del>ker</del> Wils	on B.	Kirk	er		n Durnin	s, maden	ourname	
Maryland	should and N is ma		19a. Informant's N	me/Relationship (7)	ype, Print)		20613 <sup>ii</sup>	ng Address (Street	and Number of	Ashburn	<b>V</b> Aity o	7 <b>201 49</b> te, Zi	p Code)
	and 2 Health em 27 ther t		Colleen 20a. Method of Dis		daughter		2061	4 Hilary osition (Name of	Way, A	shburn, V	A = 20	)147	
Baltimore,	age 1 ant of nt: If it y or o		1 🗌 Burial 2		Removal from State	cei	metery, crer	matory or other pla		Date	1	Location - City or	
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			snock, or nea	rt failure. List only o	plications that caused ne cause on each line	the death.							Approximate Interval Between
	Ph sician/ Medical		Immediate Cause disease or condition resulting in death)		a. Henri	I,	die	1 7	hom 6	oc- Lig	ودراون		Onset and Death
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68760	ifficate ng phy as the	Med	IF FEMALE:										
9 X	th cert ttendir or use	Physician/Medic	23b. Was decedent in the past 12		23c. If yes, outcome 1 Live Birth	2 Fetal	death 3	Ectopic pregnar	су		1	23d. Date of de	*
. Box	ne dea / the a ched fi	ysic	1 Yes 2 9 Unknown	□No	4 ☐ Pregnant a 9 ☐ Unknown	t time of de	eath 5 L	Other (specify)				Month	Day Year
P.0	requires that the de been signed by the should be detached		Part II. Other signit	ficant conditions of	ontributing to death b	ut not resul	Iting in the u	underlying cause g	ven in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
ds,	quires en sig ould be	ted t	_	_						_   1□	Yes 2	No 3□F	robably 4 🗆 Unknown
Sor	law rei nas be s 2 sho	Completed by								24a. Was	s an opsy	prior to	rtopsy findings available completion of cause of
Be	sician; The la certificate ha rector, page		05.111							perl 1 🗌 Yes	formed3	death? lo 1 🗆 Ye	s 2 🗆 No
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of\	g Physier this neral dir	te: To	27. Manner of Deat	h _	28a. Date of inju	ry 2	8b. Time of	28c. Inju	y at ☐ Nursir	ng Home 5 Res 28d. Describe			cify)
ion	Attending F death. ctor: After y the funera	ilica	1 Natural 2 Accident 3 Suicide	5 Pending Investigation 6 Could not b		, rear)	injury	M 1 🗆	k? I Yes 2 □ No	,			
Division of Vital Records,	or A after Dire in b	Certificate:	4 Homicide	determined	28e. Place of Inju building, etc		ne, farm, str	eet, factory, office		28f. Location City or To			ral Route Number,
	Hospital 24 hours Funeral leted filled	Medical	29a. Certifier 1	Certifying Phys	sician: To the best of	my knowled	dge, death	occured at the time	e, date and place	ce, and due to the c	ause(s) a	nd manner as st	ated.
	To the Ho within 24 To the Fu complete		(Check 2 only one) 3	☐ Medical Exami	ner: On the basis of e se Practioner: To the	xamination a	and/or inves	tigation, in my opin	on, death occur	red at the time, date	and place	e, and due to the	cause(s) and manner stated.
	Vith To 1		29b. Signature and	title of certifier				29c. Licens	e number	Tir.	29d. Da	ate signed (Mont	
		-	30 Namo and add	ace of names whe	completed cause of d	ooth /ltc 0	20/75	Drint)	054	17	19	102	12010
6	A 10		CO/a	Male Land	Simple led cause of d	Leaun (ittem 2	(Iype, F	5 5.	1.54-	MS	>	2180	12010
Í	Stat Registra	-	31. Date filed (Mont	h, Day, Year)	32. Registra	ır's Signatuı		. 4.1					1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Octube Year O/O Physician/ 4:28 PM Elizabeth Schnebly Niemyer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown Washington Washington County Hospital 8. Date of Birth (Month, Day, Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🖫 F Hours 216-22-9319 85 1925 **Director** May Pennsvlvania Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? P and Mental Hygiene. is marked other than "natural", or items 23a or aumatic event, the Medical Examiner must be r with 1 Funeral 20009 Rosebank Way 21740 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify: If Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Acquisitions Curator Library permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: if item 27 is marked other amy injury or other traumatic event, tt onee. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Paul С. Niemyer Helen Elizabeth Schnebly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Z. Sulcheck 1185 Mt. Aetna Road, Hagerstown, Maryland 21740 Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 10-14-10 Hagerstown, Marvland 21. Signature of Funeral Service Licensee

R. hoel Brad Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, 21740 Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ RECUMBENT HOURS disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** EMILI MATTER MOEK! Sequentially list conditions. Examine rany, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a someoquenee of) the burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? ō Month Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown a 🗌 Unknown detached cate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by URSTRUCTIVE 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an MENINGIOMA certificate has autopsy performe Yes 2 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ၉ After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending n 24 hours after death. e Funeral Director; A 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical 1- Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the I only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

WH-5

State Registrar FOX

29b. Signature and title of certifier

RA

Name and address of person who completed cause of death (Item 23a) (Type, Print) BRANFO

29d. Date signed (Month, Day, Year)

HAGERSTOWN,

			For	State of Mar	yland / Depa	artment of H	lealth and N	Mental Hygi	ene			
		•	For State Registrar		Cei	rtificate of I	Death	Re	g. No? ()	0	3359	6
			1. Decedent's Name (First, Middle, La	ist)				2. Date of Death Month		Year	3. Time of Dea	
	Physici /Medic		John A	. 0z1u					10, 201		2:35 p	• M
	Examin		4a. Facility Name (If not institution, gir	ve street and number)		4b. City, Town, or	r Location of Death		4c. County of			
			24 Courthouse		. 211	Rockvi	11e	8. Date of Birth	Mont	gome 9 Birtho	ry lace (State or Fo	oreian
	Funeral		, , , , , , , , , , , , , , , , , , , ,		(In yrs. last birthday) 55 Yrs.	Months Days	Hours Min.	Jan. 5,	Year) 1955	Coun	key	. orgi
	Director		171-42-5210 Usual Residence of Decedent					Jan. 39				
	yland yland		10a. State 10b. County	1	0c. City, Town or Lo	cation				11	0d. Inside City Li	
	72 hours after death with the Maryland natural", or items 23a or 28a-f show deal Eventher mat be netfled at	Director	Md. Montgo:	mery	Rocl	kville					1 <b>X</b> Yes 2	
	or 28	Ji e	10e. Street and Number			10f. Zip Code		10	0g. Citizen of W	/hat Coun	try?	
	23a ust b		24 Courthouse S				0850		U.S			
	tems	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		Was Decedent of H If Yes, specify Cuba	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- o Rican, etc.)		e - Americ k, White, e	an Indian, etc.	
36	safte	by F	1 Married 2 Married 3 Widowed 4 Divorced	1 □Yes 2 🛛 No If Yes, Give Year or Dates:		1∐Yes 2⊠No	Specify:		Specify:	Whi	te	
21215-0036	hour Itural	ed	15. Decedent's E		16a. Dece	dent's Usual Occup	oation		16b. Kind of Bu	siness/Ind	dustry	
15	in 72 n "na	plet	(Specify only highest gr	ade completed) College (1-4or 5+)	`life.	kind of work done DO NOT use retired	during most of word d)	king				
212	filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12)	5+		Lawyer			La	w		
b	al Hyg othe	Be C	17. Father's Name (First, Middle, Las	t)			18. Mother's Nam	ne (First, Middle, N	1aiden Surnam	e)		
Maryland	should be filed within and Mental Hygiene. is marked other than aumatic event, the Manatic event, the Manati	2	Cavit Ozlu				Cemile					
ar	2 sho and is ma		19a. Informant's Name/Relationship	(Type. Print)	19b. Maili 671	ng Address <i>(Street</i> 5 <b>North</b>	and Number or Ru 27th Str	iral Route Number, eet	City or Town,	State, Zip	Code)	
	1 and 2 Health em 27 i		Nilgun Ozlu Tunc	eli/Sister	20b. Place of Dispo	lington,	virginia	22213	20c. Location -			
Baltimore,	ges 1 and 2 should be filed within 72 hours after death with the Marylan at of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other fraumatic event, the "Medical Expuri		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cre Magnolia Nat. Memor	matory or other place Lslamic Ga	oct.	13,		•		
ţ	t. Partmer rtant;		4 □ Donation 5 □ Other (Spec		Nat. Memor	rial Park	ess of Facility De		Falls C		h, Va	
Bal	permit. Pages 1 Department of H Important; If ite any injury or ot		21. Signature of Funeral Service Lice	+ /)							D C 2000	0.7
			23a Part 1 Enter the sease or cor	1 Com			onsin Ave			ton,	D.C.200( Approximate	
			23a. Part 1. Enter the 45 ase, or cor shock, or heart failure. List only Immediate Cause (Final	one cause on each line			1	/	/		Interval Between Onset and Dea	∌n ith
	Physician / /Medical		disease or condition resulting in death)	a. Due to (a a a	consequence of):	c car	(do svas	Llav W	10 84 8	2	JH)	4
T	Examiner			Due to ( * a * a	consequence or).						,	
		ĕ	Sequentially list conditions, if any, leading to immediate	b. Due to (or se d.	consequence of):					- 0		
1)	cuted nd ransit	Ē	il any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C								
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8760,	ate br hysici he bu	<u>ica</u>		d								
39	ertific ling p e as t	Mec	IF FEMALE:	00 - 1/								
Box 6	ath co	jan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	Fetal death 3	Ectopic pregnanc	су			te of deliv onth	ery Day Yea	ar
0	the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at t 9 ☐ Unknown	ime or death 51	Other (specify) _	-					
σ.	that the ed by		Part II. Other significant conditions	contributing to death but	not resulting in the u	underlying cause giv	ven in Part I.	23e. Did tob	pacco use cont	ribute to t	he cause of deat	th?
ds	uires sign Id be	d b	Obserte.					1 □ Ye	es 2□No	3□ Pro	bably 47 Unk	nown
Records,	v req	Completed by	5277					24a. Was a	n 24b.	Were auto	opsy findings ava	ailabļe
Re	he la e has	Ę.						autops perforr 1 □ Yes	med?	prior to co death? 1 ∐Yes		se oi
tal	an: T tifica tor, pa	Be C	25. Was case referred to medical				26. Place of Dea	ath (Check only on		100		
of Vital	ysici is cer direc	.0	examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 ☐ Inpatien	t 2 ER/Outpatie	ent 3 DOA Ott	her: 4  Nursing H	lome 5 Reside	ence 6 🗆 Oth	ner (Speci	fy)	
٥	ng Ph terth neral	Ë	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day,	/ 28b. Time of Injury	of 28c. Inju	ury at ork?	28d. Describe ho	ow injury occur	red		
<u>.</u>	endir sath. or: Ai	ätic	2 Accident investigati			M 1	]Yes 2 □No					
Division	r Atter de irecto	Certification: To	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		y - At home, farm, st (Specify)	reet, factory, office		28f. Location (Si City or Town	treet and Numb n, State)	oer or Rur	al Route Numbe	<i>T</i> ,
	urs af ral D	ပိ		Physician: To the best of	f and the state of	th one yeard at the f	time date and place	o and due to the	nausa(s) and m	anner ac	etated	
	Hosp 24 hou Fune tely f	Medical	29a. Certifier 1 Certifying I (Check only one) 2 Medical Ex	aminer: On the basis of aminer state	examination and/or i	nvestigation, in my	opinion, death occ	urred at the time, o	late and place,	and due	to the cause(s)	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit	Med	29b. Signature and title of certifier	The manner state		29c. Licen	ise number	2	29d. Date signe	d (Month	Day, Year)	
	1		en o anh	o le inc	DME	10 c	00428		oct	11	2010	>
	6		30. Name and address of person wh	o completed cause of de			Y HOLL	Kogliu	+ 4	La-		
				THER, N			18x 90	rima	mo	200	304	
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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1353 PM Physician/ Ernest P. Ogden, Jr. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Examiner Allegany Western Maryland Regional Medical Center Cumberland 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 **X** M 2 □ F Days Hours Min 236-32-5030 September 29, 1925 West Virginia Director Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director Maryland Allegany Frostburg 1 Yes 2 No 10f, Zip Code 54 Tarn Terrace 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 21532-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry ife. DO NOT use re Wood Buyer permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me 4 College (1-4 or 5+) DO NOT use retired) Elementory/Seconday (0-12) Paper Mill Be 17. Father's Name (First, Middle, Last)
Ernest P. Ogden 18. Mother's Name (First, Middle, Maiden Surname) ည Nora Fortney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 54 Tarn Terrace Frostburg Maryland 19a. Informant's Name/Relationship (Type, Print)
Ruth Odgen 21532wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery crematory or other place Cumberland Crematory Cumberland Maryland October 13, 2010 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Name and Address of Facility
 Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532
 Lhola: 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCAR DIAC Priysician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical SHOC P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No been signed by the atter should be detached for Month Day Year 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy 1 Yes 2 No Yes 2 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo 1 Monpatient 2 ER/Outpatient 3 DOA မ 24 hours after death.
Funeral Director: After this leted filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Matural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) 00064167 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOShin Qaisrani, MO 600 MEMORIAL AUE. CUMBERLAND MS

State

Registrar

31. Date filed (Month, Day, Year)

14

3. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State State Registrate PROF #23a(d) perMD, 10/21/10, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 9Day 2010ear 845 PM<sub>M</sub> Physician/ Stanley B. Plotkin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Shady Grove Adventist Hospital Social Security Number Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Min. Hours 2 M231/7034 Nebraska 1**x**□ M 2 □ F Director 506-34-7909 75 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No Rockville MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral United States items 23a 20850 505 Golden Oak Terrace permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important if item 27 is marked other than "never any injury or other transmission." Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. White 1 Never Married 2 Married ģ 1 Yes 2 No Specify If Yes, Give 1953-1961 Year or Dates: 953-1961 Specify Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private 5+ Lawyer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Paula J. Jaskolka Solomon J. Plotkin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 505 Golden Oak Terrace Rockville MD 20852 Carol Plotkin - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garden of Bemembrance
Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/12/10 Clarksburg, MD 21. Signature of Foneral Service Licenses 22 Name and Address of Facility M01163Edward Sagel Funeral Direction Inc 1091 Rockville Pike Rockville MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final tailure cardiac Privsician, disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner infarction myo cardia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): 5 hock or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury Ptic attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Spinal Stenosis IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant a 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Kidhen discuse 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an tibrillation has autopsv page 2 performed? this certificate obesity 25. Was case referr d to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 🔀 Yes 2 🗌 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 Natural 5 Pending Investigation Accident the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: After completed filled in by Hospital

10

Medical

29a. Certifier

(Check only one) 29b. Signature and title of certifier

31. Date filed (Mor

30. Name and address of pe

argenter,

DHMH 17 Rev 7/2009

State Registrar son who completed cause of death (Item 23a) (Type, Print)

9901 Medical

gistrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Center Drive

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

20850

October,

Maryland

Rodeville

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 11 Physician/ 2010 7:23 A T. Pizzoferrato Betty Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Kline House Airy If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** 1 □ M 2**X** F Months Davs Hours Min. oct 13, Year) West Virginia 85 **Director** 235-20-9370 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1 Kenneth Drive United States P.O. Box 84 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces þ 1 Never Married 2 Married 1 ☐ Yes 2 ☒No Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify: Specify: Completed 3 ₩ Widowed 4 □ Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) 12 County Clerks Office Secretary and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ William Α. Tolbard Snyder Mary В. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau Mary P. Hise/daughter Kenneth Drive P.O. Box 84 Walkersville, MD 21793 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 10/14/2010 Woodbine, Maryland 21. Signature of Funeral Service Licensee Going Home Cremation Service P.O. box 784 Beverly L. Heckrotte, P.A. Clarksville, M uanta Homas M00957 MD 21029 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause one ach line. Immediate Cause (Final Physician/ disease or condition resulting in death) Ment Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death signed by the a 9 I Inknown 9 Unknow Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 🗍 No 3 🗌 Probably 4 📈 nknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has I autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 2 **N**O 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Mother (Specify) → SOC P 27. Manner of Deal 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 5 Pending 1 Yes Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b, Signature and title of certif 29d. Date signed (Month, Day, Year)

Registrar

State

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of Ma	•	partment of H e <i>rtificate of D</i>			Reg. No.	10	33600
			Decedent's Name (First, Middle,	Last)				2. Date of Dea	ath	Year	3. Time of Death
	Physicia Medio			erbert Pal	еу			Octobe		010	8:16 P M
	Examin	er	4a. Facility Name (if not institution,	give street and number)		4b. City, Town, or			4c. County		mary
1.00	Funeral		Casey House  5. Social Security Number	6. Sex 7. Age	e (In yrs. last birthda	Rockv y) If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	Iontgo 9. Birthp	lace (State or Foreign
	Director		578-50-5286	1 <b>X</b> M 2 □ F	71 Yrs	Months Days	Hours Min.	May 5,	1939	Washi	ington, DC
	land show d at		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				1	0d. Inside City Limits
	/aryla 8a-f s tified	Funeral Director	Maryland Monto	gomery	Dic	kerson					1 🗆 Yes 2 😾 No
	a or 2 be no		10e. Street and Number			10f. Zip Code			10g. Citizen of		
	h with	ner	20311 Peachtree			208				ed Sta	
	r deat or iter niner	by Fu	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☒ Marri</li></ul>	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🏋		<ol><li>Was Decedent of His If Yes, specify Cubar</li></ol>	spanic Origin? (Spo n, Mexican, Puerto	ecity Yes or No- Rican, etc.)		ce - America ack, White, e	
99	rs afte iral", c Exan		3 Widowed 4 Divorced	If Yes, Give Year or Dates.	140	1 ☐ Yes 2 🔀 No	Specify:		Specify	<sup>y:</sup> Whi	.te
2-0	2 hou "natu edical	plet	15. Deceden (Specify only higher	t's Education st grade completed)	(G.	cedent's Usual Occupa ve kind of work done d	ation uring most of work	ing	16b. Kind of E	3usiness Ind	dustry
21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at	Completed	Elementary/Seconday (0-12)	College (1-4 or 5 <b>5+</b>	+)	Lawyer			Law		
д 5	iled w Il Hygi I othe vent,	Be	17. Father's Name (First, Middle, La			<u> </u>	18. Mother's Nam	ne (First, Middle,		1e)	
ylar	ould be file nd Mental I marked o	잍	Frank Paley	<i>I</i>			Sara	Brill			
Jar	should and Me rs mar raumati		19a. Informant's Name/Relationsh	-		ailing Address (Street a					
e, l	and 2 s Health tem 27		Lana Parvizian,	/wife		11 Peachtr sposition (Name of		Dickers	20c. Location	_	
nor	Page 1 anent of hand the ant: If its ury or of		1 ☐ Burial 2 🔀 Cremation 4 ☐ Donation 5 ☐ Other (S)		cemetery, o	rematory or other place	9)	1		•	
Baltimore, Maryland	せきせき		21. Signature of Funeral Service L			rney Crema					
m	permi Depar Impor any ir	7. 7	Quanto Ox	24homas						sville	784 e, MD 21029
			23a. Part Enter the disease, or shock, or heart failure. List o	complications that caused nly one cause on each line	the death. Do not	enter the mode of dying	g, such as cardiac	or respiratory an	rest,		Approximate Interval Between Onset and Death
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U		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence of):						
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_	sate be executed physician and the burial-transit	ial E	resulting in death) Last	Due to (or as a	a consequence of):						
Box 68760	icate t phys	ledical		d							
89	ath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		3   Ectopic pregnanc	v			ate of delive	
<b>B</b> 0	the att	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown		5 Other (specify)			M	lonth	Day Year
Ö.	that the dea ned by the a detached f		Part II. Other significant condition	ns contributing to death b	ut not resulting in t	ne underlying cause giv	en in Part I.	23e. Did to	obacco use con	ntribute to th	ne cause of death?
3, F	w requires that is been signed to should be detailed.	d by						1 🗆	Yes 2 🗆 No	3 🗆 Prot	bably 4 🛚 Unknown
ord	w requisite been	Completed						24a. Was		. Were autor	psy findings available mpletion of cause of
Rec	sician: The law i certificate has t irector, page 2 s	ပ္ပ						perfo	rmed?	death?	2 □ No
ta	ician: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:		Othe	ace of Death (Chec				
Ž	Physic ruthis caral dir	은 :	1 Yes 2 No 27. Manner of Death	1 L Inpati	ent 2 ER/Outpa ry 28b. Tim	e of 28c. Injury	4 ☐ Nursing H	ome 5 Resid			<u> Hospice</u>
on c	nding ath. r: Afte ie fune	icate	1 Natural 5 Pendin 2 Accident Investig	ation	<i>y, Year)</i> inju		? Yes 2 □ No				
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certificate:	3 ☐ Suicide 6 ☐ Could a 4 ☐ Homicide determ			street, factory, office	•	28f. Location (S City or Tow	Street and Numi	ber or Rural	Route Number,
۵	pital cours at eral D eral D filled i		29a. Certifier 1X Certifying	Physician: To the best of	my knowledge, de:	ath occured at the time	date and place, a	nd due to the ca	use(s) and man	ner as state	ed.
	le Hos n 24 hu le Fun oleted	Medical	(Check 2 Medical E	xaminer: On the basis of e Nurse Practioner: To the	xamination and/or in	vestigation, in my opinio	n, death occurred a	at the time, date a	and place, and d	lue to the cal	use(s) and manner stated.
	To the To the Comp	-	29b. Signature and title of certifier	00	/	29c. License	number		29d. Date sign		
			46	Ver V d		D37	142		10 - K	7-5	-010
	15		30. Name and address of person of G. Coleman, M.		eath (Item 23a) (Typ. ccard Dr		lle, Mar	vland 2	0850		
	Sta	te		00.00	ar's Signature		TTE, LIGI	y Land Z	0000		
	Registr		00113	2010 32. Registra	n B.	parker	_				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

		-	For State Registrar	ate of Maryla		artment of H tificate of D		ind Mental Hy	Glene Reg. No	ZUIU	33601
	Physicia		1. Decedent's Name (First, Middle, Last)  Preston A. Pairo	o Tr				2. Date of De		<sup>ay</sup> 201 <sup>Y</sup> 6 <sup>ar</sup>	3. Time of Death 3:00 A M
	Medic Examin		4a. Facility Name (if not institution, give street			4b. City, Town, or	Location of			c. County of Death	1.000
			9032 Overhill Drive			Ellico				Howard	
	Funeral Director		5. Social Security Number 6. Sex 1 3 M	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	8. Date of Bir Min. (Month, Da Jun 5,	<sup>th</sup> 192	7 9. Birth	place (State or Foreign Tryland
	nd thow at	j.	Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	cation					10d. Inside City Limits
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	a or 2 be no	io le	10e. Street and Number			10f. Zip Code				itizen of What Cou	
	th witl ms 23 must	Funeral	9032 Overhill Drive	Vas Decedent Ever in	110 112 1		1042	in? (Specify Yes or No-		nited St	
က	er dea or ite	by Fu	1 ☐ Never Married 2 ☐ Married 1	Armed Forces?		f Yes, specify Cubar	n, Mexican,	Puerto Rican, etc.)		Black, White,	
ğ	urs aft :ural", al Exal	ted	3 U Widowed 4 U Divorced	f Yes, Give fear or Dates.		I ☐ Yes 2 🙀 No					hite
15-	72 ho n "nat Aedica	Completed	15. Decedent's Educati (Specify only highest grade co	mpleted)	(Give	dent's Usual Occupa kind of work done d O NOT use retired)		of working	16b. I	Kind of Business Ir	ndustry
212	within giene.		Elementary/Seconday (0-12)	College (1-4 or 5+) 5+	I	ttorney				Law	
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<u>₹</u>	d Men d Men marke matic	-	Preston A. Pairo  19a. Informant's Name/Relationship (Type, P.		10h Maili	a Addross (Street s		ossom Pr	itch		Codel
Ma	I 2 shouth and the sh		Preston A. Pairo, I		I	-		ourt Wood			
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Ë	Page ment tant: I		1 ☐ Burial 2 🔀 Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	Fin				10/12/2010	Wc	odbine,	Maryland
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	nca MC	) 0957   B	oing Home everly L.	s Crem Heck	ation Serv	ice Cl	P.O. Box arksvill	: 784 e, MD 21029
ı			23a. Party. Enter the disease, or complication shock, or heart failure. List only one call	ons that caused the d							Approximate Interval Between
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Division of Vital Records, P.O.	e law re e has be ge 2 sh	Completed						perf	opsy ormed?	prior to c death?	opsy findings available ompletion of cause of 2 $\square$ No
a R	an: Th tificate tor, pa	Be C	25. Was case referred to medical			26. PI	lace of Death	1 🗌 Yes h (Check only one)	2 (2)	10 TLL Yes	2 L NO
Z.	hysici his cel il direc	<u>ا</u>	examiner? 1 ☐ Yes 2 🔀 No	1 ☐ Inpatient 2			4 ∐ Nur	rsing Home 5 X Res			fy)
n of	ding P h. After t funera	:ate:	1 □xNatural 5 □ Pending	28a. Date of injury (Month, Day, Year	28b. Time o injury	work		28d. Describe	how inju	ry occurred	
isio	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	8e. Place of Injury - A building, etc. (Spe					(Street a	nd Number or Run	al Route Number,
<u>≤</u>	ital or urs afte ral Dir lled in										
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	To the To the Compl	2	29b. Signature and dittle of Cortiver	To the best o	,ougu,	29c. License		,,		ate signed (Month	
			MATOR			1311	172		00	toh 10	12010
l	ot		30. Name and address of person who compl	eted cause of death (I	- Da	288 (	20141	MEIA N	AFY	400	2044
	Sta Registr		31. Date filed (Month, Day, Year) <b>OCT 13 201</b> 0	32. Registrar's Signatur	gnature	barker					, 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ RR M Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** ANNE ARUNDEL ANNAPOLIS ANNE ARUNDEL MEDICAL CENTER Age (In vrs. last birthday If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Hours 06/13/1959 Director MARYLAND 216-76-0694 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 is marked other than "nature" any injury or other traumatic events. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No MD ANNE ARUNDEI ANNAPOLIS 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 21401 USA 708 - DNEWTOWNE DRIVE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc Armed Force Yes 2 No þ 1 Never Married 2 Married 1 Yes 2X No Specify: If Yes, Give Specify: BLACK Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER 10 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ CLARA CROMWELL BENJAMIN FRANKLIN PERRY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1408 LOG INN ROAD ANNAPOLIS, MD 21409 BOBBY CROMWELL / BROTHER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 10/14/2010 STEVENSVILLE, MD CENTER . Signature of Funeral Service 22. Name and Address of Facility FELLOWS HE CREMATION & FUNERAL CARE, P 814 BESTGATE ROAD ANNAPOLIS HELFENBEIN & NEWNAM Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death Immediate Cause (Final Physician/ 4 NG disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or imjury attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Pregnant Unknown ate has been signed by the a page 2 should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? hours after death. uneral Director: After this certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 Tes 2 No Certificate: To Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death funeral 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury work? Natural 5 Pending Accident Investigation the f Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 ☐ Medical Examiner: On to 3 ☐ Certifying Nurse Praction only one) Signature and title of certifie 29c. License numbe 2010

State Registrar me and address of per

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31. Date filed (Month, Day, Year,

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eted cause of death (Item 23a) (Ty

32. Redistrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October ZO 10 Physician/ lius M. Proctor 12:30 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Pineview Clinton ture care George 9. Birthplace State or Foreign 8. Date of Birth Social Security Number 6. Sex 7. Age (In vrs. last birthdav) If Under 1 Year If Under 24 Hrs. Funeral Washington De Months Days Hours Min Day, 1 🕅 M 2 🗆 F 80 Director 577-40-8141 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 No Prince Suitelan Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3525 Terrace 20746 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 1 No 14. Race - American Indian, 11. Marital Status Black White etc. 2 1 Never Married 2 Married If Yes, Give Year or Dates. 1 Yes 2 No Specify: "natural" Completed 3 Widowed 4 Divorced Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hyglene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government 12 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health Important: If item 27 MUZAN 4500 Mornine 20746 Kent 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) injury or MD 4 Donation 5 Other (Specify) 10-15-10 Cheltenhan Vetern 21. Signature of Funeral Service Ucenses 22. Name and Address of Facility 20608 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory anest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): that the death certificate be executed burial-transit and Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? been signed by the atte should be detached for Day Pregnant at time of death Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ dembitus alcer 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 \( \subseteq \text{ Yes} \) 2 \( \subseteq \text{ No} \) Hitery 24a. Was an has page 2 Parlanson Wiseuse certificate Yes 2 N 25. Was case referred to medical Hospital or Attending Physician: director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 X No 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death. To the Funeral Director: After this funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 2 No 2 Accident 3 Suicide 4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сотрыете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗆 only one

3altimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

State Registrar 29b. Signatu

e and title of certifie

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

2835 Smith Arence

29c. License number

M90233337

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29d. Date signed (Month. Day, Year)

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2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2010 6:15 A M October Doreen Elizabeth Planck Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Keedysville 6802 Smoketown Road Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year \_\_\_ If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year) 0V. 9, 1944 Country) W York 65 Director 062-36-0688 Nov. New Usual Residence of Decedent show or 28a-f shown notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location death with the Maryland Director 1 🗆 Yes 2 💢 No Keedysville Maryland Washington ıral", or items 23a or Examiner must be n 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6802 Smoketown Road 21756 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 X Married ☐ Yes 2X No within 72 hours after Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural" 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other thany injury or other traumatic event, the once. 8 Physician Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Eugene Kelly Dorothy Secor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6802 Smoketown Road Keedysville, Maryland Jeffery C. Planck / Son 21756 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 10/21/2010 4 ☐ Donation 5 ☐ Other (Specify) Hemlock Church Cem. Buckhannon, WV 21. Signal tre of Funeral San Ice Licensee 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA 7606 Old National Pike Boonsboro, MD 21713 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ metastatic colo-rectal cancer disease or condition resulting in death) months Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter oncertying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ò Month Day Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ ☐ 9 ☐ Unknown detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by breast cancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an sacral pressure u/cer autopsy certificate has page 2 performed? 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medica funeral director. Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home Hospital 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 24 hours after death. Funeral Director: After (Month, Day, Year) injury work? 1 Natural 5 Pendina Investigation Accident filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number determined Hospital Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

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completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) Cynthea Kuturer-Sands . so 047451 October 13 2010

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cynthia Kuthner-Sandsmo Hospice of Washington County

Hasenst

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 33605 1 - State AMEND#26perMD, 10/15/10, EMW, MbCb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day **Year** 7:39 P M <u>Janice</u> L. Rosenfeld October 0 Medical 4b. City, Town, or Location of Death Bethesda 4a. Facility Name (if not institution, give street and number) County of Death Montgomery **Examiner** Suburban Hospital 8. Date of Birt 2/01/1939 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 □ M 2 🛣 F ŽÔ Months Days Hours Min **Director** Ohio 295-32-4600 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death wift, the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Rockville 1 X Yes 2 No Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 6111 Montrose Road #1029 20852 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: White 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Dental Assistant Dental Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Unknown Unknown Anne Luft 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11208 Blackhorse Court, Potomac MD 20854 Craig S. Rosenfeld - son 20a. Method of Disposition

A Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Garden of Remembrance Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 10/10/10 Clarksburg, MD 21. Signature of Funeral Service Lie 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels Inc
1170 Rockville Pike Rockville MD 20852 M01163 23a/Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DIEALE filysician/ CARDIDVINICUL MADIO SCI EN disease or condition Medical resulting in death) **Examiner** S countielly list conditions if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Day Month Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 After this certificate 2 No 1 🗌 Yes of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 K ER/Outpatient 3 ☐ DCA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work Division 1 🗌 Yes 2 🗌 No Accident Investigation filled in by the Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3 N s of person who completed cause of death (Item 23a) (Type, Print) 20814 BYD GURGETTUN N 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 3 Registrar

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		•	For State Registrar	Otato of ma	i yidiid / D	Certifica	ate of D	eath		Reg. No		_	
ı	Physicia	n/	1. Decedent's Name (First, Middle, Last						2. Date of Dea		y 2010 ar	3. Time of Death	
	Medic Examin	al	GLYNDOLA C. ROSS  4a. Facility Name (if not institution, give:			I dh. C	ty Town or	Location of Deat		$\overline{}$	. County of Death	6:49 p M	
	, Examin	eı	WASHINGTON ADVEN		ΓAL		AKOMA				ONT GOMERY	Y	
İ	Funeral Director		3/3-02-94/6	x □ M 2 💢 F 82	In yrs. last birth	/rs. If Un Monti	der 1 Year ns Days	If Under 24 Hrs Hours Min.		h y, Yea <i>r)</i> 927	9. Birthpla Countr RED S	PRINGS, NC	
	and show Lat	or	Usual Residence of Decedent  10a. State 10b. County	T-	10c. City, Town	or Location					10	d. Inside City Limits	
	Maryla 28a-f	irect	DC		WAS	HINGTO	N_	_				1X Yes 2 □ No	
	s 23a or 3	Funeral Director	10e. Street and Number 1737 BUCHANAN ST.	NE			Zip Code 0017			•	tizen of What Count		
2-0030	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status  1 □ Never Married 2 【 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates.			cedent of Hi becify Cuba 2 🌠 No		pecify Yes or No- to Rican, etc.)	- 1	14. Race - America Black, White, et Specify: BLA	tc.	
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Mar	d 2 should be filk sath and Mental n 27 is marked o er traumatic eve		19a. Informant's Name/Relationship (Ty,			-					Town, State, Zip Co	ode)	
baitimore,	Page 1 and 2 s ment of Health i ant: If item 27 i ury or other tra		20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif)		20b. Place of cemetery FORT L	y, crematory o INCOLN	or other plac	10/		BREI	NTWOOD, M	ARYLAND	
pall	permit. Page 1 Department of Important: If i any injury or once.		21. Signature of Funeral Service Liminsee  22. Name and Address of Facility JOHN T. RI 3005 12th ST. NE WASHINGTO								ON, DC 20712		
7	Trysician/	ì	shock, or heart failure. List only or Immediate Cause (Final disease or condition	e cause on each line.	RIO	SCLI	207.	EC No	SAKII	Szs	5855	Approximate Interval Between Onset and Death	
	Medical Examiner		resulting in death)	Due to (or as a d	R / C	-VS:	-VS	- WS	RRI /	125	5 ASE		
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POX O	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/	23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death	3  Ectop 5 Other		у		1	23d. Date of deliver Month	ry Day Year	
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UNISION	ral or Atter s after des al Director ed in by th	Il Certificate:	3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homicide determined		/ - At home, far (Specify)	m, street, fac	tory, office		28f. Location (\$ City or Tov	Street an vn, State	d Number or Rural I )	Route Number,	
_	the Hospit nin 24 hour the Funera npleted fill.	Medical	(Check 2 Medical Examinonly one) 3 Certifying Nurs	ician: To the best of m ner: On the basis of exa e Practioner: To the b	mination and/or	investigation, edge, death or	in my opinic curred at the	n, death occurred time, date and p	at the time, date a	and place e cause(	e, and due to the caus s) and manner as sta	se(s) and manner stated. ted.	
	To To Con		29b. Signature and title of certifier	nu	1	;	29c. License	26/4		29d. Da	te signed (Month, D	lety, Year) 10	
0	10		30. Name and address of person who c DR. DON COLEMAN				IA DAD	V MD 200	12				
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	Registra		OCT 1 3 2010	Beauti B	. Day								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) Date of Death
 Month Dolores Robison 912 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Western Maryland Regional Medical Center Allegan (Lumberland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. e. Birthplace (State or Foreign 8. Date of Birth 1 □ M 2 🛣 F Months Country) Maryland (Month, Day, Year) February 05, 212-38-7163 1936 Usual Residence of Deceder 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Allegany Mt. Savage 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 16022 Callah Hill Rd 10g. Citizen of What Country? 21545-U.S.A 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1. Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: 3 Divorced 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) O<sup>College</sup> (1-4 or 5+) Elementary/Seconday (0-12) seamtress Clothes Making

18. Mother's Name (First, Middle, Maiden Surname)

21545-

Maryland

Elizabeth Hoye

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Mt. Savage

or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0036

For State Registrar

10a. State

17. Father's Name (First, Middle, Last)

Bonnie Gaughan

Clayton Robison Sr.

19a. Informant's Name/Relationship (Type, Print)

sister

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

925

Sidhu,

Director

Funeral

Completed by

To Be

Physician/

Medical

**Examiner** 

**Funeral** 

**Director** 

Ph sician/ Medical Examiner

cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit

within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

Medical Certificate: To Be Completed by Physician/Medical Examiner

7	20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)	20b. Place of Disposition cemetery, crematory St Michaels	or other place)	Date October 13,	I	Location - City of rostburg	r Town, State Maryland
V. AN.	21. Signature of Funeral Service Licensee		ne and Address of Faci urst Funeral Ho		Ave., Fr	ostburg, M	D 21532
	if any, leading to immediate cause. Enter Underlying Cause (Disease or iin]ury that initiated events c.	d the death. Do not enter the e.  a consequence of):  a consequence of):  a consequence of):			-		Approximate Interval Between Onset and Death
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  \  \text{Ves} 2 \  \text{VNo} \\ 9  \  \text{Unknown} \  \text{Unknown} \	2 Fetal death 3 Ecto	opic pregnancy er (specify)			23d. Date of de Month	elivery Day Year
	Part II. Other significant conditions contributing to death to SEASIS OF UNI	out not resulting in the underly	-				o the cause of death?  Probably 4 Julynknown
					Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
	25. Was case referred to medical examiner?		26. Place of De	eath (Check only one	)		
	Hospital:	ient 2 ER/Outpatient 3 [	DOA Other: 4	Nursing Home 5	Residence	6 Other (Spe	cifu)
	27. Manner of Death  1 1 Natural 5 Pending (Month, Date of Inju.) 2 Accident Investigation	ry 28b. Time of	28c. Injury at work?	28d. Desc		ury occurred	<i>5.17</i>
177	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injudiding, etc.	ury - At home, farm, street, fa c. <i>(Specify)</i>	ctory, office		tion (Street a or Town, Sta		ural Route Number,
	29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of each only one) 3 Certifying Nurse Practioner: To the	xamination and/or investigation	n, in my opinion, death	occurred at the time,	date and pla	ce, and due to the	cause(s) and manner stated
	29b. Signature and title of certifier		29c. License number		29d. [	Date signed (Mon	th, Day, Year)
	> Hidh		126907	1	00	TUBER	112010

12922 St. Georges Lane

nos

State Registrar Harjit

31. Date filed @

Bishop Walsh Drive, Cumberland, MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33608 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2010 Year October 3 135 A Nelson Westley Stalker Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda Social Security Number Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛣 M 2 🗆 F (Month, Day, Ye Director 91 MI 382-09-5226 May Usual Residence of Decedent show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2x No MD Gaithersburg Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20877 United States 11 Brookes Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 ₩ Widowed 4 Divorced WW II Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Locksmith Locksmith Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Andy Stalker Margaret Harvie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Stalker - Son 11 Brookes Avenue, Gaithersburg, MD 20877 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date UKN 20c. Location - City or Town, State permit. Page 1 and Department of Hall Important: If ite any injury or ot 1 X Burial 2 Cremation 3 X Removal from State Garfield Township Cemi Fife Lake, MI 4 Donation 5 Other (Specify) 21. Sign stars of Fune al Service Licentee 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels Inc II/O Rockville Pike Rockville MD 20852 M01163 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Mitial Regargitation Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Pnuemonia Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Acute Respiratory Failure that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 X No 1 Yes 2 No Be ( 25. Was case referred to medical examiner? of Vital 26. Place of Death (Check only one) 2 X No မှ 1 Yes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d, Describe how injury occurred injury work?
1 Yes 2 No 1X□ Natural 5 Pending Division 2 Accident
3 Suicide
4 Homicide Investigation To the Funeral Director:
Ocompleted filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State Registrar 29b. Signature and tit

31. Date filed (Month, Day, Year)

OCT

13

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NECON 10103/10

Atul Rohatgi MD 8600 Old Georgetown Road, Bethesda MD 20814

29d. Date signed Month, Day, Year,

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			101	oartment of Health and Nertificate of Death	Mental Hygien	2010 33600							
	Physicia		1. Decedent's Name (First, Middle, Last)  Joseph M. Saah		2. Date of Death Month October 10	3. Time of Death							
	Medic Examin		4a. Facility Name (if not institution, give street and number)  9720 Corkran Lane  5. Social Security Number   6. Sex   7. Age (in yrs. last birthday)	4b. City, Town, or Location of Death  Bethesda  If Under 1 Year   If Under 24 Hrs.	4	4c. County of Death Montgomery							
	Funeral Director		579-12-4825   1x M 2 G F   Regidence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Pay, Year 07/07/192	9. Birthplace (State or Foreign Country) 1 Israel							
	Maryland 28a-f show stified at	Director	10a. State         10b. County         10c. City, Town or I           MD         Montgomery         Bethesd			10d. Inside City Limits							
	with the s 23a or 2	Funeral Di	10e. Street and Number 9720 Corkran Lane	10f. Zip Code 20817	10g. ( Uni	Citizen of What Country? ited States							
9036	permit. Fage I and 2 should be littled within 72 hours after dearn with the Maryland permit. Fage I and 2 should be littled by Jejene. Important: If them Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ World If Yes, Give War II	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2X No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White							
Baltimore, Maryland 21215-0036	vitnin 72 no jiene. er than "nai the Medica	Completed by	(Specify only highest grade completed) (Giv Elementary/Seconday (0-12) College (1-4 or 5+)	edent's Usual Occupation a kind of work done during most of work DO NOT use retired)  repreneur	ting	. Kind of Business Industry							
/land	d be med v Mental Hyg arked othe	To Be	17. Father's Name (First, Middle, Last)  Mousa Saah		ne (First, Middle, Maide Unknown	n Surname)							
, Mar	adth and Padth a			ling Address (Street and Number or Rur Cockran Lane Beth									
imore	rage I arment of Ho ant: If iter ury or oth			position (Name of lematory or other place) Neaven Cemet. 10/1		Location - City or Town, State  1ver Spring, MD							
Balt	Departi Departi Import any inj once.		William R. Bugg 5	22. Name and Address of Facility $f Jos$ $130$ $f Wisconsin$ $f Ave$ .	NW Washir								
	nysician/ Madical xaminer	resulting in death)  a. Due to (or as a consequence of):  #uperten xiva											
60 September of the state of the september of the septemb	attending physician and for use as the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):										
ISION Of VITAL RECORDS, P.O. BOX 68760 Attending physician: The law requires that the death certificate he executed	y the attending p	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy  1 □ Live Birth 2 □ Fetal death 3  4 □ Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year							
S, P.O	been signed by the should be detached	d by PI	Part II. Other significant conditions contributing to death but not resulting in the End Stage Renal Disease	underlying cause given in Part I.		o use contribute to the cause of death?  2 ፟፟፟፟【No 3 ☐ Probably 4 ☐ Unknown							
Division of Vital Records, alor Attending Physician: The law requires	certificate has beer irector, page 2 shou	Completed by			24a. Was an autopsy performed?								
Ital	is certific director,	Be	25. Was case referred to medical examiner?  1  Yes 2 XNo  Hospital: 1  Inserting 3 FR/Output	26. Place of Death (Chec									
on of V	ath. : After this e funeral di	cate: To	27. Manner of Death  1 ☐ Inpatient 2 ☐ ER/Outpati 28a. Date of injury (Month, Day, Year)  28b. Time injury  Accident Investigation	ent 3 □ DOA 4 □ Nursing Ho	ome 5 K Residence 28d. Describe how inj								
Division	building, etc. (Specify)												
the Hosnit	hin 24 hour the Funer:	29a. Certifier (Check only one)  1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one)  1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Intriting Numer Practioner Tell to be for my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Intriting Numer Practioner Tell to be for my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Intriting Numer Practioner Tell to be for my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
	100		29b. Signature and tive of certifier	29c. License number D21340		Date signed (Month, Day, Year)							
	10		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)		ctober 11, 2010							
	Stat	9	Raymond A. Bass MD, 15225 Shady Grov 31. Date filed (Month Ray Year) 32. gistrar's Signature	e Road #302, Rocky	ville, MD 2	20850							
	Registra	ır	31. Date filed (Monto CTYear) 3 2010 32. gistrar's Signature	backs									

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 25aper med cert G909 11/4/10 dk.
State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1 Month Day 2010 Year Rudolph Benjamin Smith Sr. 7 12:10 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Althea Woodland Nursing Home Montgomery Silver Spring Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 10 Month, Day, 1918 9. Birthplace (State or Foreign 3irthpiac Country VA **Funeral** Months Days Hours 228 10 3235 92 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location s 23a or 28a-f show 10d. Inside City Limits 1√Yes 2□No VA Richmond 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1021 German School Rd.Apt. 23225 Funera USA r than "natural", or items Was Deced Armed Forces? 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo Specify. <u>გ</u> 3<sup>™</sup> Widowed 4 □ Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 721 (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within? Department of Health and Mental Hygiene. Important; If item 27 is marked other than "in any Injury or other transment." Elementary/Secondary (0-12) College (1-4or 5+) Private Laborer (Plaster) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Smith Mabel M. Mason 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14000 Farnsworth La.#3408 Upper Marlboro, MD 19a. Informant's Name/Relationship (Type. Print) Rudolph B. Smith, Jr./ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State Forest Lawn Cem. 10/12/2010 Richmond, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Chiles Funeral Home, Inc. of Funeral Service Lice 2100 Fairmount Ave.Richmond, VA 23223 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a ~ Groma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical the attending ph IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) P.O. hed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 sign 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1∐Yes 2**∑**No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 24 hours after deatl Funeral Director; 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) October 8 2010 Name and address of person who completed cause of death (Item 23a) (Type, Print) MB 428 Queenshing Rollingth wille MD 20781 DEVORE 31. Date filed (Month egistrar's Signature Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 5 mall wood nom as 1cto ber 2010 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 9. Birthplace (State or Foreign NC country) (in vrs. last birthday) Social Security Number Min. X M 2□F Months Days Hours 0470871930 245 42 1714 80 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County MD Baltimore Y Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1216 North Potomac Street 21213 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married Black 1 □Yes 2\Ot\o Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Steel Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Wiley Jade Bazemore Johnny Jackson Smallwood 19a. Informant's Name/Relationship (Type. Print)
Florence R. Smallwood/wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1216 N.Potomac St.Baltimore, MD 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Windsor, NC Family Cemetery 10/17/2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gilliam Funeral Home 21. Signature of Funeral Service Licens 706 Ghent St.Windsor, NC 27983 23a. Par1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hum S ACUTE LISTING disease or condition resulting in death) Due to (or as a consequence of): ZIMMINI US SMMCTIN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ums EMALY SEMA Due to (or as a consequence of): IF FEMALE: A 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Xes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a Was an autopsy 2 🕽 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 X ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

law requires that the death certificate be executed burial-transi attending physician Box 68760. the as) nse s ģ P.0. the cate has been signed by page 2 should be detact Division of Vital Records, The certificate

Examine Physician/Medical Š Completed Be

**Physician** 

/Medical

Examiner

Funeral

Director

28a-f show

23a

or items

"natural",

12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r

.. Pages 1 and ... ment of Health and 27 is

other t

Department of Heall Important: If item 2 any injury or other

**Physician** 

/Medical

Examiner

72 hours after

Saltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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traumatic event, the Medical Examiner must be notified at

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral filled in by the

Certification: To

Medical

State

Registrar

29b. Signature and title of certifier

6 Could not be determined

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

OCTUSION 11, 2010

MO 21751

BMI MANO,

Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LUCH NOWN SUND 3 WIT MO 5601 ENGUNS

31. Date filed (Month, Day, Year) OCT 13

3 Suicide

29a, Certifier

4 ☐ Homicide

(Check only one)

32 Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental HygieRe 1 - State Registre Certificate of Death 2. Date of Death Month I. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Frances Virginia Smallwood October 11, 2010 18:08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10808 Archer Lane Williamsport Washington If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign Country) West Virginia **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 M 2/5/F Yrs. Director 219-44-2926 68 June 6, 1942 Usual Residence of Decedent the Maryland 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 28e-f show item 27 is marked other than "natural", or items 23a or 28e-f show other treumatic event, the Marilea Example restrict out the retified at 1 ☐ Yes XXNo Directo Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 10808 Archer Lane 21795 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after in and Mental Hygiene. Is marked other than "natural", or Ite 1 Never Married 20 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXVo Specify: Specify: White 2 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Registered Nurse Medical 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lawrence Russell Williamson Frances Lucille Cooley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ages 1 and 2 nt of Health a t: If item 27 I D.James Smallwood, Sr. - Husband 10808 Archer Lane Williamsport,MD 21795 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or otl 1 Burial 2 Cremation 3 Removal from State 4 Donation XXOther (Specificated mbment Greenlawn Mem. Park 10-15-2010 Williamsport, Maryland ture of Fyneral S 22. Name and Address of Facility Osborne Funeral Home, P.A. 425 S.Conococheague St. Williamsport, MD 21795 Approximate Interval Between Onset and Death 3 12 Yecon 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Priysician tallocion Tube disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed the burial-transit attending physician and Due to (or as a consequence of): Box 68760 Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Year 4☐ Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 2 ER/Outpatient 3 DOA his 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 4166 Relan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Come urmack 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 6:35 PM OCTOBER 06,2010 Roger James Smack /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MANOKIN MANOR PRINCESS ANNE SUMERSET If Under 1 Year Months Days Birthplace (State or Foreign Country)
 Maryland 8. Date of Birth (Month, Day, Year) 9 / 1 3 / 1 9 2 9 5. Social Security Number 7. Age (In vrs. last birthday Funeral Hours 1 M 2 □ F Yrs. 214-28-3375 Director 81 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinator must be inviting at 1X Yes 2 □ No Director Somerset Princess Anne MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21853 11974 Edgehill Terrace Road Funeral Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □Yes 2 ☒No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate 12 Agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Hayward James Smack ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 318 Silvia Road, Stockton, MD 21864 Elizabeth Aydelotte (daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of Important: If it any injury or o IM Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity Garden of Memory 10/9/2010 Newark, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Holloway Funeral Home, Professional Association 21. Signature of Funeral Service Licenses 107 Vine Street, Pocomoke City, MD 21851 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Demenha 5 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause [Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy nerform rmed? 2 No 1 ☐Yes 2 ☐ No certificate 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manyer of Death 28c. Injury at Work? 28d. Describe how injury occurred After t Natural
Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide If Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 005/359 Ochber 1/2 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1415-5. DIVISION ST, SALISBURY MD 21804 BAI NATES AN 9 ·USITA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

OCT 12

SMACK,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 27, 2010 Physician/ 8:30 A M William L. Taylor Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Pikesville 218 Hawthorne Avenue 8. Date of Birth
(Month, Day, Year)
Feb. 20,1908 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 D F Hours Maryland 21905-7249 102 Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10a. State 10c. City, Town or Location Examiner must be notified at Director Yes 2 No Pikesville Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Numbe USA 21208 Funeral items 23a 218 Hawthorne Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces
1X Yes 2 Black, White, etc. þ 1 Never Married 2 Married 2 🗆 No "natural", or 3altimore, Maryland 21215-0036 Black 1943-1945 1 Yes 2X No Specify: Specify. If Yes Give 3 X Widowed 4 Divorced Year or Dates the Medical 16a Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. County Board of Elementary/Seconday (0-12) College (1-4 or 5+) High School Science Teacher Education permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) ပ Anna Blake Edward Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 218 Hawthorne Avenue, Pikesville, MD 21208 Tiffany Brown 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State Chesterfield Cemetary 10-02-10 Centreville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Henry Funeral Home P.A. 21. Signature of Funeral Service Licensee nelle 510 Washington Street, Cambridge, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 01-01-2000 Immediate Cause (Final Physician/ COPD disease or condition Medical Examiner Medical resulting in death) Due to (or as a consequence of): 08-01-2010 Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) 09-01-2010 attending physician and for use as the burial-transit C. diff that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year be detached for Month Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementia 2 X No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of Syncope 24a. Was an autopsy performed' death? I or Attending Physician: The after death.

Director; After this certificate! Lung mass/abscess 1 ☐ Yes 2 ☐ No Yes 2 XNo filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: ဥ 2**X** No 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred XX Natural injury work? 5 Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. сотретен (Check only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of 09-28-2010

Registrar
DHMH 17 Rev 7/2009

State

705 Digital Drive, Suite G, Linthicum, MD 21090

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Augustina Olajumoke Opeewe CRNP

31. Date filed (Month, Day, Ye

OCT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-07713 State of Maryland / Department of Health and Mental Hygiene Winfred D. Turner 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death Physician/ 1. Decedent's Name (First, Middle, Last) Month October 7, 2010 1550 hrs Medical Examiner infred urner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Talbot Easton Memorial Hospital 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number Funeral Foreign Mary land Months Min Director 960 12-72-0575 1 M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Ves 2 No Easton Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Director 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 2160 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14 Race - American Indian Black Funeral 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 V Never Married 2 Married Yes Yes 2 No specify. 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Flementary/Secondary (0-12) ost Driver 17. Father's Name (First, Middle, Last If item 27 is marked Be ia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ambridg High 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Mid Shore Cremation Donation 5 Other Specify: 22. Name and Address of Facility Henry Funeral Hom 510 washingtonst. 21. Signature of Funeral Service Licensee 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or bear Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical a Dilated Cardiomyopathy Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last g physician and the burial - trans sician/Medical UNPENDED AMENDED requires that the death certificate be Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown ned by the a detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? o. ģ 1 Yes 2 No 3 Probably 4 Unknown σ. Completed Records, ficate has been s. page 2 should b 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? 1 🗸 Yes ✓ Yes 2 No certificate 26.Place of Death (Check only one) 25. Was case referred to medical the Hospital or Attending Physician: of Vital Be Hospital: 1 Inpatient 2 Other4 Nursing Home 5 Residence 6 Other: ER/Outpatient 3 DOA this 1 V Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 1 V Natural Pending 1 Yes 2 No Division the Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. hours after Could not be Suicide within 24 hours a Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 / Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number October 8, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD

DHMH 17 Rev 1/2001 OCME 2006

State Registrar 2. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Betty Jane Twigg 11:10 PM October Medical 4b. City, Town, or Location of Death Cumberland 4c. County of Death Allegany 4a. Facility Name (if not institution, give street and number) **Examiner** Lions Ctr for Rehab & Ext Care 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 02/04/1926 Country) Maryland 1 □ M 2 🖫 F Months 84 215-20-6140 Yrs Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Director MD Allegany Cumberland 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21502 USA Funeral 13407 Bealls Mill Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: "natural", 3 X Widowed 4 ☐ Divorced Completed White other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Pre-School Assistant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental 7 Hansrote Mae Edward Adam 1 and 2 should be of Health and Me item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24221 Preakness Drive, Damascus, MD Amy Anders / Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date permit. Page 1 and Department of I Important: If ite any injury or ot cemetery, crematory or other place)
Hillcrest Mem. Park 10/15/2010 1 X Burial 2 Cremation 3 Removal from State Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. Signature of Funeral Service Licenses 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Bilateral Physician/ ewuelle disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Seven at Recivin devertion Few yean Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury and I-transit Exami that initiated events Due to (or as a consequence of): physician ar s the burial-t resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day ☐Yes 2☐No 9 Unknown Division of Vital Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Ptriation 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has death? 2 No this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 X Nursing Home 5 A Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D46346 October 12, 2010 Hrma Steel 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Huma Shakil, M.D., 625 Kent Avenue, Cumberland, MD now Huma Shakil, M.D., 31. Date filed (Month, Day Year) 2010 2. Registrar's Signature State andred Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	u.,, =	Certifi	cate of l	Death		,,,	Re	g. No.		
Physicia	n/	Decedent's Name (First, Middle,Last)	•						Date of Deat Month		ır	3. Time of Death
ledical Examii		John William White I							Month October 9,			2355 hrs
		4a. Facility Name (if not institution, give street				. City, Town, o	or Location o	of Death		4c. County o		
		Peninsula Regional Medical Cer		ura laat k		If Under 1 Ye	as Milado	r 24Hrs.	Date of Birt			hplace (State or
Funeral Director		5. Social Security Number 6. Sex		yrs. last b		Months Da		Min	12/14/		Foreig	n Maryland
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any	ŀ	10a. State 10b. County	100	c. City, Tov	vn or Location	n						10d. Inside City Limits
<b>*</b> .	_	Maryland Wicomico		Pa	rsonsb	urg						1 Yes 2 X No
Maryland 28a-f show at at once.	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of Wh	nat Cour	ntry?
tiffed the N		5725 Argyle Drive				21	849			Ţ	JSA	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she rother tranmatic event, the Medical Examiner must be notified at once	Funeral		as Decedent Ever med Forces?	er in U.S.		Decedent of H				14. Race White		can Indian, Black,
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s afte rral",	<u>a</u>	3 Widowed 4 Divorced If Yes, or Date  15. Decedent's Education (Specify only high	S:	ted) 16:		es 2 A N	o specify: ation (Give )	kind of worl	k done	Specify: 16b. Kind of Bu		
2 hour	ğ		llege (1-4 or 5+)			st of working lit						•
21215-0036 uld be filed within 72 how Mental Hygiene. marked other than "nat c event, the Medical Exp	Completed	9		R	oofer					Constru	ıcti	on
D 21215-003 should be filed within and Mental Hygiene. The is marked other that event, the Med	डी	17. Father's Name (First, Middle, Last)				-	18.Mother	's Name (F	irst, Middle, N	laiden Sumame	)	
2121 uld be fil Mental F marked	Be	John William White,					_		Daisey			
D 21 hould nd Me is ma	$\vdash$	19a. Informant's Name/Relationship (Type, Pr								ber, City or Tow		
re, MD 2 1 and 2 shou Health and N fitem 27 is n		Lois Jean White/Mothe	r			on (Name of c			Lsbury Date	Mary 1a		
of He	İ	1 X Burial 2 Cremation 3 Rer	noval from State	crem	natory or othe	r place)						
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Baltimore, permit. Pages I an Department of Hea Important: If iter injury or other tr.		21. Signature of Funeral Service Licenses 2	aller	_	Zel	me and Addre ler Fur 2 Old	neral	Home,	P. O.	Box 31 Salisbu	171	MD 21802
Physician		23a. Part I. Enter the disease, or complication	s that caused the	death. Do	not enter the	mode of dying	g, such as ca	ardiac or re	spiratory arre	est, shock, or he	art	Approximate Interval
/Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Sadd	e Pulmonary	Thromb	ooembolis	m						Between Onset and Death
Examiner		or condition resulting in death) Due to	(or as a conseque	ence of):			_					5
		Sequentially list conditions,	Venous Thro		, Left Leg						_	
	jne	cause. Enter Underlying Cause	or as a conseque	ance or).								
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760, cate be ex physician he burial	Medical				011					23d. Date of	deliven	,
876 tificat ng phy as the		23b. Was decedent pregnant in the	If yes, outcome of Live birth	n pregnani		l death 3	Ectopic	pregnancy	/	Month		Day Year
Box 687  death certific the attending p	Physician/	past 12 months?  1 Yes 2 No 9 Unknown	Pregnant at time	e of death	5 Othe	er (Specify)						
O. Boy at the deatl d by the att	چّا	Part II. Other significant conditions contril	Unknown	it not resul	ting in the un	derlying cause	given in Pa	art I	23e Did to	bacco use contr	ibute to	the cause of death?
, P.O. Borres that the de signed by the	b	left heel injury	duling to death bu	it not resur	ting in the dir	derrying cada	giverrint					pably 4 🗸 Unknown
rds, l	Completed	lett ricer injury			-				24a. Was a			topsy findings available
COFC law re has be	ed l	<del></del>						_	autop: perfor	med?	death?	completion of cause of
tal Rection: The certificate ector, page	5					00.01	(D#-	/Ob I I	1 Yes	2 No 1	<b>√</b> Ye	es 2 No
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical examiner? Hospital	Innatient	2 FR	/Outpatient	_	Other4	-		Residence 6	Other	-
of Vital Records, ing Physician: The law require. After this certificate has been si funeral director, page 2 should t	<u>۱</u>	1	a, Date of Injury		b. Time of Inj		jury at Work	? 28	d. Describe h	now injury occurr	ed	
on Control of the fun	tion	E Pending	ct 9, 2010	22	257 hrs	1	Yes 2	No Si	ıbject fell 1	from machin	егу	
Division tal or Attendi rs after death. al Director: #	ertification:	2 Accident Investigation 3 Suicide 6 Could not be	Be. Place of Injury	- At home	, farm, street	, factory, office	building, et	c. 28			er or Ru	ral Route Number, City
Divi	erti	- Guicide	Specify) Single	Family	Home			61	or Town, S 13 Steve St	reet, Salisbury	, MD	
Hosp 24 ho Fun etely f	alC	29a. Certifier 1 Certifying Physician: To	the best of my kr	nowledge,	death occurre	ed at the time,	date and pla	ace, and du	e to the caus	e(s) and manner	r as state	ed.
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the finneral director, page 2 should be detached for use as the state of the control of the said	Medical		basis of examination basis of	ation and/o	or investigatio			curred at th	e time, date a			
	Σ	29b. Signature and title of certifier	11				nse number			29d. Date sign October 10		
Λ.		Panielf ruthon	U,MI)				.M.E.			October 10	, 2010	
7		30. Name and address of person who comple Pamela E. Southall, MD Assi	ed cause of deat stant Medica			Penn Stre	et, Baltim	ore. MD	21201			
	ol:	31. Date filed (Month, Day, Year)	3. Registrar's		BOA		,					
Si	ate	OCT 1 0 STITE	A	A	1300 PM							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-1 - For Amend 26 per physical Registrar DOR, 10/6/10, LDB

1. Decedent's Name (First, Middle, Last) Certificate of Death 2. Date of Death 3. Jime of Death September Physician Day Year 4a. Facility Name (If not institution, give street and number) 0307AM 2010 /Medical Ford Examiner 4b/ City, Town, or Location of Death 4c. County of Death General HOSpital Cambridge Dorchester 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec. 31 Birthplace (State or Foreign Country) **Funeral** 214\_34\_8887 Usual Residence of Decedent 1 **™** M 2 □ F Months Days Min. Year) Hours Director Maryland 10a. State 10c. City, Town or Location 28a-f show 10d. Inside City Limits filed within 72 hours after death with the Marylar ntal Hygiene. ed other than "natural", or Items 23a or 28a-f shov event, the Medical Exercines must be notified at Director 1 Yes 2 □ No lorchester Hurlock 10e. Street and Number 10g. Citizen of What Country? 21643 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 1 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Stodi 2 should be filed w and Mental Hygie is marked other ti 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item Z7 Is marked any injury or other traumatic evonce. Ge Woolford ပ 19a. Informant's Name Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beu Ellen lah RoudHurlo 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 22. Name and Address / Facility Henry Funercy Home, P. A. 4 ☐ Donation 5 ☐ Other (Specify) JOHNS reston maryland 21. Signature of Funeral Service Licensee SIC Washington St, C ambridge, MD, 21613 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death **Physician** Christing Arrh disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ronn Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consquence of): Hospital or Attending Physician: The law requires that the death certificate be execute and burial-trar Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by icate has been si , page 2 should b 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate of Vital 2 No 1 ☐ Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home Certification: To 1 Yes 2 4No. 1 ☐ Inpatient XX ER/Outpatient 3 ☐ DOA After this - 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 ☐ Pending investigation 24 hours after death. Funeral Director: ₽ 2 Accident 1 ☐Yes 2 ☐ No filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) within 2 29b. Signature and title of conflier ٥ 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mic Adden 302 31. Date filed (Month, Day, Year) Registrar's Signature 32 State OCT 08 Registrar

935				for State Amend	Pleas	se Type or Pri AMEND I State of M b,c per MD	<b>nt in</b> EM#2 arylan RG	Black 3a, po d / De FCHD	indelil erME, de partme	ble Int 910, ent of F 3/10, r	k. Ensure 12/16/201 lealth and	<b>All Copie</b> IU, WS Mental Hy	s Ar	e Legible.		20
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701	ġ	Examin		4a. Facility Name (if	not institution, g	ive street and number)	Shady H <b>gs</b>	Gro	Ye 4b. Cit	ty, Town, or	Location of Death	ockville	4	c. County of Deat	Montg	omer
s)		Funeral Director		5. Social Security N 519-94-		. Sex 7. Ag	e (In yrs. I 48	as <i>t birthda</i> Yrs	Month	der 1 Year s Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 0 4 / 1 5	rth 7 1 9 (	9. Bir Co	hplace (State or F untry) VA	oreign
OCTOBER		Maryland 28a-f show otified at	tor	Usual Residence of 10a. State	10b. County		10c. Cit		r Location						10d. Inside City I	
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	920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Mari 3 ☐ Widowed		12. Was Decedent Armed Forces? d 1 Yes 2 If Yes, Give Year or Dates.	/	S. <sup>2</sup>		edent of Hi ecify Culsa 2 🖾 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	oecify Yes or No- o Rican, etc.)	-	14. Race - Ame Black, White Specify: WH	e, etc.	
7	215-0036	2 hour "natu edical	Completed	(Spe	15. Decedent	s Education grade completed)		1 (G	ecedent's Us	ork done o	ation during most of wor	king	16b.	Kind of Business	Industry	
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3	Maryland 2	id be filed v Mental Hyg arked other atic event,	To Be	17. Father's Name (		FERGUS,	JR.				18. Mother's Nar				DeROSA	
17	, Mar	nd 2 shou ealth and n 27 is m er traum		19a. Informant's Na		POUSE		19b. M 120	ailing Addre	uss (Street a	and Number or Ru HIP TRA	ral Route Numbe	er, City o	or Town, State, Zij	0 6 5 7	
ERI	Baltimore,	Page 1 ar nent of He ant: If iter Iry or oth			position Cremation 5 Cher (Sp	Removal from State	20b. F	Place of Di cemetery, TTEF	isposition (N crematory or DAY	lame of r other plac SAI	NTS 10/	Date 11/201	20c.	Location - City or HAMPST	Town, State EAD, NC	!
CH	Balti	permit. Departr Importa any inju		21. Signature of Fu	neral Service)Li	ensee M			22. Name	and Addres	s of Facility	P	.0.	BOX 8	6 E, MD	
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		Medical Examiner		resulting in death)	1	Due to (or as	o nsequ	uence of):					0		<del>/// * / (</del>	
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	•	be executed sician and burial-transit		that initiated event resulting in death)	S	C. Due to (or as	a consequ	uence of):	//		SVS	See	<del>//</del> \	107	10	
	9760	ificate ng phys as the	Medi	IF FEMALE:		a			4	£ ~ `						
	. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 bours after death certificate be within 24 bours after death certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?	23c. If yes, outcome 1  Live Birth 4  Pregnant a 9  Unknown	2 Feta	al death	3   Ectopio   Ectopio	c pregnanc (specify)	у		5	23d. Date of de Month	ivery Day Yea	ar
	P.O	s that the gned by be detact	þ	Part II. Other signit	ficant condition	s contributing to death b	out not res	ulting in t	he underlyin	g cause giv	ven in Part I.				the cause of deat	
	ords	require been si should	Completed									24a. Was	an	24b. Were au	topsy findings ava	ailable
	Rec	hysician: The law r his certificate has b il director, page 2 sl	Somp						-			auto perfe 1 🗆 Yes	ormed?	death?	completion of caus	se of
	ita	sician: certific rector,	Be	25. Was case referrence examiner?  1    Yes 2	ed to medical	Hospital:		5D/0 /		Othe	ace of Death (Che			а П он	· · ·	
	J of V	ling Phys	ate: To	27. Manner of Deat	h 5 Pending	28a. Date of inju (Month, Da	ıry y, Year)	28b. Tim inju	ry r	28c. Injury work	/ at	28d, Describe	how inju		or Linco	
	Division of Vital Records, P.O.	or Attend after death Director: / In by the f	Certificate:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	Investiga 6  Could no determin	t be 280 Place of Ini	unc At ho	me, farm,	1			28f. Location (	Street a		ral Route Number, ランプッソン MJ 2つ	1EW
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evin Anthony \	Villia	1- For State	e of Maryla		artment rtificate			and N	viental	Hygiene	Reg. N	. 20	10	33621
Physici edical Exami	an/ iner	Registrar  1. Decedent's Name (First, Middle,La KEVIN		HONY		WI	LLIAMS	5		2. Date of I Month Octobe	Death Day	/ Year		3. Time of Death 1759 hrs
		4a. Facility Name (If not institution, g 424 Ridge Road Apt. 7	ive street and nur	nber)		4b	Greenbe		ation of De	ath		4c. County of Prince Ge		s
Funeral Director			Sex XM 2 F	7. Age (In yrs. l: 34		) Yrs.	If Under 1 Months		f Under 24H Hours N	/lin	f Birth(Mi		9. Birth Foreign Cour	place (State or GUYANA ntry)
Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiest Income 1 Department of Health and Mental Hygiest Income 23 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	10e. Street and Number 424 RIDGE ROAD 1 11. Marital Status 1 Never Married 2 Married	12. Was Deck Armed Fo 1	edent Ever in U. rces? 2 \( \subseteq \text{No} \) e completed) 4 or 5+)	19b. Ma 424 Place of Discrematory o	Was If Yes  Decedent of s, specify Curves 2 Susual Occupit of working FT OP:  Address (SIDGE R. On (Name of r place)  DLN CE. me and Additional Control of the control o	Hispaniban, Me No sp upation life DO ERAT  18.M Utreet an OAD Cemete METE ress of F	exican, Pue pecify: (Give kind d NOT use r COR Mother's Na DEBRA d Number of #7 GF erry, ERY 9,	me (First, Midd HAYNES or Rural Route REENBEL Date /22/201 . B. JE	US No-	White, Specify: Kind of Busi PRIVA en Surname) City or Town, ARYLAN C. Location - C RENTWO S FUNE	America etc.  BLA ness/Inc TE State, 2 City or T. OD, 1 RAL	an Indian, Black,  ACK dustry  Zip Code)	
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ar ar	by Physician	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknow  Part II. Other significant conditions  Cirrhosis of	1 Live bi 4 Pregna vn 9 Unkno	utcome of pregi rth ant at time of de wn death but not re	nancy 2     eath 5	Fetal Othe	death	3 <u> </u>	ectopic preg	23e. Di 1	d tobacc Yes 2	3d. Date of de Month  o use contribu  No 3  24b. We price	Da  ute to th  Probal  ere auto or to cor	y Year  e cause of death?  bly 4  Unknown  psy findings available  mpletion of cause of
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn.	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending Investigation  1 Natural 5 Pending Investigation  1 Natural 5 Pending Investigation  1 Yes 2 X								performed?  1  Ves 2 No 1 Ves 2  Of Death (Check only one)  Other4 Nursing Home 5 Residence 6 Other. Scene  y at Work?  28d. Describe how injury occurred  unknown  28f. Location (Street and Number or Rural Route Numor Town, State)  424 Ridge Rd. Apt. 7 Greet  te and place, and due to the cause(s) and manner as stated.  death occurred at the time, date and place, and due to the cause(s)			Scene  Il Route Number, City  7 Greenbelt  I.  cause(s)		
		30. Name and address of person who Donna M. Vincenti, MD	completed cause Assistant M			11 F		et, Ba		MD 21201	Oc	ctober 12,	2010	
St Regis	tate trar	31. Date filed (Month, Day Year) OCT 2 1 2010	32. Rec	gistra s Signa	and									

DHMH 17 Rev 1/2001 OCME 2006

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33622 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death October 9<sup>Day</sup> 2010<sup>Year</sup> Physician/ 12:37 PM Maurice Lee Watson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 415 Links View Drive Washington County Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) Funeral (Month, Day, Days Min Country) Maryland 1 X M 2 - F Director 216-14-7443 85 June Usual Residence of Deceden ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 💢 No Maryland Washington Co. Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 415 Links View Drive 21740 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 X Yes 2 1943 to
If Yes, Give 1945
Year or Dates. 1945 1 Never Married 2 X Married Completed by 72 hours after Saltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White and Mental Hygiene. is marked other than "natural", 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Contract Specialist Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Maurice Michael Watson Elizabeth L. Cross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Jean Elizabeth Watson/ Wife 415 Links View Drive Hagerstown, Maryland 21742 20a. Method of Disposition 20c. Location - City or Town, State
Timonium 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ABurial 2 Cremation 3 Removal from State Dulaney Valley Mem. Gardens 10-13-2010 Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 331 Eastern Blvd. North. Hagerstown 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Congestive ears disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine sician and burial-transit Hyperreusion

Due to of as a consequence of): resulting in death) Last physician s the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown in the past 12 months? Month Day 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 has autopsy perform Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending after death. 1 Yes 2 No 2 Accident Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) 24 hours a Hospital Medical 1 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) D28810 October 11. 2010

**3**H /1+1 State

Registrar

MANAIC

31. Date filed (Month, Day, Year)

BLASH

14

OCT

Suite 204

Hagerstown MD

12916 Conamar

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1- State State Registrar Ce	rtificate of Death		010	33623
	Physici	an	1. Decedent's Name (First, Middle, Last)		Date of Death     Month	Day Year	3. Time of Death
	/Medic		STANFORD WILBUR ZOLLNER		10	3 /0	a043 M
	Examin	er	4a. Facility Name (If not institution, give street and number)  Western MD Regional Medical Center	4b. City, Town, or Location of De Cumberland	eatn	4c. County of Dear  Allega	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year   If Under 24 F			thplace (State or Foreign
	Director		217-14-4941 1 XM 2 ☐ F 84 Yrs.  Usual Residence of Decedent	Months Days Hours M	08/06/19	926 M	lary1and
	land ow		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	a-f sh	ctor	MD Allegany LaVale				1 □ Yes 2 😾 No
	ith the	Dire	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Co	ountry?
	ath w	eral	12422 Butler Drive, N.W.	21502		U.S.A.	
215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Model Evandre of 1815 to 1811 to 1811 for all	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Never Married 5 Never Married  1 Never Married 5 Never Married  1 Never Married 5 Never Married  1 Never Married 5 Never Married  1 Never Married 5 Never Married  1 Never Married 5 Never Married  1 Never Married 5 Never Ma	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu  1 □Yes 2 ▼No Specify:	(Specify Yes or No- lerto Rican, etc.)	14. Race - Ame Black, White Specify: Wh	
2-0	72 hou	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation	vorking 16	6b. Kind of Business	/Industry
	within lene. <b>than</b> "	mple	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of v DO NOT use retired)		VALOE OUR	
d 21	illed w Hygie ther t		12 OW	ner/Operator	Name (First, Middle, Ma	AUTO BODY	REPAIR
Maryland	12 should be filed w h and Mental Hygie 7 is marked other th traumatic event, th	To Be	James Zollner		dys Rinker	arden earmaine,	
ary	shoul and M s marl umati	Ĕ	19a. Informant's Name/Relationship (Type. Print) 19b. Mail	ng Address (Street and Number or	Rural Route Number, (	City or Town, State, .	Zip Code)
-	1 and 2 Health a tem 27 is		Martha Lee Zollner / Wife 12	422 Butler Drive	e, N.W., La	Vale, MD	21502
ore	Pages 1 nent of He int: If iten iry or oth		20a. Method of Disposition 20b. Place of Disposemetery, creation 3 ☐ Removal from State 20b. Place of Disposemetery, creation	osition (Name of matory or other place)	Date 20	Oc. Location - City or	Town, State
Baltimore,	permit. Pag Department Important: I any Injury o		4 □ Donation 5 □ Other (Specify) Rose Hill		/07/2010	Cumber1a	
Bal	permit. Pages Department of Important: If it any Injury or once.		Mary whench	2. Name and Address of Facility T 202 Greene Stre	eet, Cumber	land, MD	e, P.A. 21502
Н			23a. Part LEnter the disease, or complications that caused the death. Do not er shock, or heart fallure. List only one cause on each line.		diac or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final V disease or sondition resulting in death)	trrhythma			minutes
-	/Medical Examiner		Due to (or as a consequence of):	erosts			years
		Jer	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	010313			years
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events .				
90,	icate be executed physician and the burial-transit		resulting in death) Last  Due to (or as a consequence of):				
68760,	icate t physic the b	Aedical	d				
_	certific nding p	υ/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of de	livery
Box	death cer ie aftendir ed for use	Physician/⊪	in the past 12 months?   1 Live birth 2 Li Fetal death 3	☐ Ectopic pregnancy ☐ Other <i>(specify)</i>		Month	Day Year
P.0.	that the dened by the a	Phys	9 LI UNKNOWN				
	8 5 6	þ	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.			o the cause of death? robably 4 ☐ Unknown
cor	w require been signatures	lete			24a. Was an		utopsy findings available
Vital Records,	The lav	Completed			<ul><li>autopsy performe</li></ul>	prior to death?	completion of cause of s 2 □ No
ital	sician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?	26. Place of [	1 ☐ Yes 2 Death (Check only one)		5 2 110
of V	di si	0	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		g Home 5 ☐ Residen	ce 6 □Other (Spe	ecify)
on C	ding Ph h. After th funeral	ion:	27. Manper of Death 1 ☑ Natural 5 ☑ Pending (Month, Day, Year) 28b. Time of Injury	Work?	28d. Describe how	injury occurred	
Division	ten teat tor:	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st		28f. Location (Stre	eet and Number or R	ural Route Number.
Ω̈	al or A s after Il Dire	Certification: T	4 Homicide determined building, etc. (Specify)	,	City or Town,		
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical C	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and pl nvestigation, in my opinion, death o	ace, and due to the cau ccurred at the time, dat	use(s) and manner a te and place, and due	is stated. e to the cause(s)
	To the within 2 То the сопрые	Me	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Mon	th, Day, Year)
			burgentalho M)	D00544	f/1	10/5/	10
	12		30 Name and address operson who completed cause of death (Item 23a) (Type,	Print)	761 D. C	nadad A	10 01563
	nas		31. Date (ingh/mehit), (ray, Year) 32. Registrar's Signature	mai HVP, Ne	DI CIM	secrency ly	112 21502
	Sta Registr		31. Date find when the factor of the state o	1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Ernest Anderson		1- For State Registrar	Sta	ate of Maryla		epartm C <i>ertific</i>			Mental		Reg. No	2010	33624	
Physiciar Medical Examin		Decedent's Name     Ernest		e,Last) gene Anderson	n					2. Date of De Month October	Day	Year	3. Time of Death 1244 hrs	
· · ·		4a. Facility Name (if	not institution	n, give street and nu			4	b. City, Town, or L	ocation of De			c. County of De	ath	
Funeral	4	419 North Ea			7. Age (In y	rs. last bir	thday)	Baltimore	If Under 24h	Irs. 8. Date of B	irth(MN	1/DD/YYYY) 9.	Birthplace (State or	
Director		214-56-0136		1 <b>XX</b> M 2 F		6	51 Yrs.	Months Days	Hours N	July 26	, 19		reign Country) Maryland	
ny		Usual Residence of I	Decedent 0b. County		10c.	City, Town	or Locatio	on .	<b></b>				10d. Inside City Limits	
Maryland 28a-f show any datonce	_	Maryland				•	imore						1 X Yes 2 No	
Maryla	~ L	10e. Street and Num		<u></u>				10f. Zip Code			10g. Ci	tizen of What C	ountry?	
ith the 23a or		419 Northe	east Ave	nue 12. Was Dec	edent Ever	in II S	13 W/ss	2122 Decedent of Hispa		Specify Ves or N	0-	U,S.A.	nerican Indian, Black,	
death w	<u> </u>	1 Never Married	2 Ma	A				s, specify Cuban, I			0-	White, etc		
rs after rral", o		3 Widowed		orced If Yes, Give Year or Dates: cify only highest grad		d) [165		Yes 2 X No		f work done	146h	Specify: Black		
72 hour	Completed	Elementary/Secon		College (1-				st of working life. [			100.	Kind of Busines	ss/maastry	
within giene.		12	Total Belonda	14			Dri		N. B 10	/First Ballelan		`	g Company	
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	ا د ا ه	17. Father's Name (F Charlie E.		•				18		ne (First, Middle, e E. Clark		i Surname)		
D 21215-00; should be filed with and Mental Hygiene and Mental Hygiene is marked other it matic event, the Med		19a. Informant's Nam			`	- 1		Address (Street				-	ate, Zip Code)	
Z g g g g g g g g g g g g g g g g g g g	ŀ	Tarsha And 20a. Method of Dispo	sition	(Daughter	2	0b. Place o	of Disposit	erri Drive		, Maryland		Location - City	or Town, State	
imor Pages 1 ment of 1 tant: If or other	1	1 Burial 2 X	_	3 Removal fro		cremat tlanti	ory or othe ic Cre	• ,	10	-23-2010	G1	en Burnie	e, Maryland	
Baltimore, permit. Pages 1 ar Department of He. Important: If ite	Ī	21. Signature of Fund					22. Na	me and Address o	of FacilityGar Park		an F	uneral H	ome at Meadow-	
Physician	+	23a. Part I. Enter the			used the de	eath. Do no		e Memorial Washingtor mode of dying, su		Elkridge or respiratory ar			Approximate Interval	
Examiner		failure. List only Immediate Cause (Fi	inal disease	a. <mark>Atheroscler</mark>	otic Card	liovascu	lar Dise	ase					Between Onset and Death	
enorth.	1	or condition resulting	, , , , , , , , , , , , , , , , , , ,	Due to (or as a	consequen	ce of):								
		Sequentially list cond if any, leading to imm	nediate	Due to (or as a	consequen	ce of):								
sit of		(Disease or injury that events resulting in de		Due to (or as a	consequen	ce of):								
50, te be executed ysician and burial - transit	<u> </u>	UNPENDED		dAMENDED					<del></del>	<del></del>				
Sion of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the de th certificate be executed retor: After this certificate has been signed by the futerding physician and by the funeral director, page 2 should be detached for use as the burial - transi		IF FEMALE:	connect in the	23c. If yes, o		oregnancy	_				23	d. Date of deliv	ery	
Box 68760, e de th certificate be the trending physici of fruse as the buri	Filysicianii	3b. Was decedent pr past 12 months?		4 Pregna	rth ant at time o	of death 5		Ideath 3 er (Specify)	Ectopic preg	nancy		Month	Day Year	
he de t	2	1 Yes 2 No		9 Unkno		ot reculting		derlying cause give	on in Bort I	23o Didt	obacco	ueo contributo	to the cause of death?	
P.O. res that the signed be detac				ung Disease	death but i	iot resulting	g in the un	denying cause givi	enm Fanti.		_		robably 4 V Unknown	
ords,	completed by									24a. Was			autopsy findings available o completion of cause of	
II Reco	[										rmed?	death	?	
sician:	2   E	25. Was case referre examiner?	_	Hospital:	patient 2	□ ER/O	utpatient		f Death (Chec		Posid	ence 6 🗸 Oti	per Scene	
of Villing Physical differential	1 Yes 2 27. Manner of Death	No	28a. Date o	·	<u> </u>	Time of Inj			28d. Describe			lei. Geerle		
Division o ital or Attending ars after death. ral Director: Aft		1 ✓ Natural 2 Accident	5 Pendi	ng tigation					s 2 No					
		3 Suicide 4 Homicide	6 Could determ	not be	of Injury - A	At home, fa	rm, street,	factory, office buil	lding, etc.	28f. Location ( or Town, S		and Number or	Rural Route Number, City	
8 5 5 H	۱ د	29a. Certifier 1 C		ysician: To the best										
To the Howithin 24 P. To the Funcompletely		one) 2 V M 29b. Signature and tit		niner: On the basis of and manner sta		ən and/or ir	ivestigatio	n, in my opinion, d		i at the time, date			the cause(s)  Aonth, Day, Year)	
	1	Ana :	U H	Lacla	W			O.C.M.				ober 19, 20		
(REAL)	+	30. Name and addres	-	who completed cause			D-n C'	P-line	- MD 040	04				
Stat	e i	Carol Allan, N 31. Date filed (Month,		istant Medical E	istrar's Sig		enn St	reet, Baltimor	e, MD 212					
Registra	_	nrt 97	2010	12.	A	Sa. M.	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

hazya Bennett		- For State	laryland / Departm <i>Certifi</i> d	nent of cate of		Mental Hy	_	2010	33625		
Physicia	ın/	Registrar  1. Decedent's Name (First, Middle,Last)		-			2. Date of Death Month	g. No. n Day Year	3. Time of Death 0213 hrs		
Aedical Examii	ner	Shazya M. Bennett October 24, 2010  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death									
		Sinai Hospital	and number)	40	Baltimore	cation of Death		4c. County of Dea	1(1)		
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bi	irthday)		If Under 24Hrs.	8. Date of Birtl		Birthplace (State or Foreign		
Director	1	213-55-2143 1□M 2	<b>X</b> F 11	Months Days	Hours Min.	3-28-	-1999   `	Country) MD			
<u>*</u>		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	n or Locatio	2				10d. Inside City Limits		
Maryland 28a-f show any d at once.		MD na		timo					1 X Yes 2 No		
arylan 8a-f sl	Director	10e. Street and Number	bar		10f. Zip Code	_	10	g. Citizen of What Co	ountry?		
the M Sa or 2		522 S. Bentalou	Street		21223			USA			
eath with the Maryland items 23a or 28a-f sho ust be notified at once	Funeral		/as Decedent Ever in U.S. rmed Forces?		Decedent of Hispa s, specify Cuban, M			14. Race - Ame White, etc.	erican Indian, Black,		
은 등태		3 Widowed 4 Divorced of Yes.	Yes 2XX No		res 2 No s		,	Specify:	Black		
ours af atural'	d b	15. Decedent's Education (Specify only high	DG,	. Decedent's	s Usual Occupation	(Give kind of wo		16b. Kind of Busines	s/Industry		
n 72 h	Completed	Elementary/Secondary (0-12) Co	ollege (1-4 or 5+)		st of working life. Do	O NOT use retire	:d)	Schoo	<b>.</b> 1		
-003 d withi giene. ther th	E	17. Father's Name (First, Middle, Last)		Sti	ident	Mother's Name (	First Middle M	aiden Surname)			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh injury or other traumatic event, the Medical Examiner must be notified at once	Bec	Andre Woods			10.			. Bennet			
D 21 hould hould is man		19a. Informant's Name/Relationship (Type, Po	int ) 19	9b. Mailing	Address (Street a	nd Number or Ru	ıral Route Numl	ber, City or Town, Sta	ite, Zip Code)		
Baltimore, MD semit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumat		Dicheaker Lilly- 20a. Method of Disposition			S. Benta on (Name of cemet		reet Date	Balto, M			
DOCE ages 1: at of H t: If it		1 K Burial 2 Cremation 3 Re	noval from State crema	atory or other				Randalls			
altin nit. Pa artmen nortan	H	4 Donation 5 Other Specify: 21. Signature of Function Service Licenses	Killy		me and Address of			ast F/H	SCOWIT/IID		
Per Per Injury		Meder 1811		1.	101 E.	North	Avenue	e Balto	,MD 21202		
Physician /Medical		23a. Part I. Enter the disease, or complication failure. List only one cause on each line	s that caused the death. Do r	not enter the	e mode of dying, su	ch as cardiac or	respiratory arre	st, shock, or heart	Approximate Interval Between Onset and		
Examiner	1	100	ole Injuries (or as a consequence of):						Death		
		Sequentially list conditions, b	(or as a sorrosquerios si).								
	ji.	if any, leading to immediate Due to cause. Enter Underlying Cause	(or as a consequence of):								
d d	Examiner	(Disease or Injury that Initiated events resulting in death) Last Due to	(or as a consequence of):								
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	edical E	d. UNPENDED AME	NDED		<u>.</u>				<del></del>		
60, ate be o	Medi		If yes, outcome of pregnancy	v				23d. Date of delive	ery		
30x 6876( death certificate e attending phy for use as the b	ian/I	2h Was decadest programs in the	Live birth		death 3	Ectopic pregnan	су	Month	Day Year		
Box e death of the atten	Physician/M	1 Yes 2 No 9 Unknown g	Pregnant at time of death Unknown	5 Othe	er (Specify)						
ires that the signed by the detached	by Ph	Part II. Other significant conditions contri	outing to death but not resulting	ng in the un	derlying cause give	en in Part I.			to the cause of death?		
S, P uires ti n signe									obably 4 Unknown		
cords,	Completed						24a. Was a autops perform	y prior to	autopsy findings available o completion of cause of		
tal Reco	히						1 <b>✓</b> Yes 2				
Vital I hysician: this certifi	a a	25. Was case referred to medical examiner?	1 Inpatient 2 V ER/C	Outpatient	10.	Death (Check or	<del></del>	Residence 6 Oth	er:		
ling Phy After th	-1	1 ✓ Yes 2 No 27. Manner of Death 28	a. Date of Injury 28b.	. Time of Inj		et Work? 2	8d. Describe ho	ow injury occurred			
Sion Attendib	atio	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Year) oct 24, 2010 005	52 hrs	1 Yes	2 N/2 N/0	ubject pass ehicle accid	•	involved in motor		
Division pital or Attent ours after death teral Directors filled in by the	Certification:	Suicide Could not be	Be. Place of Injury - At home, t	farm, street	factory, office build		or Town, Sta	ate)	Rural Route Number, City		
Hospits 4 hours unera	_	4 Homicide	Specify) Local Street the best of my knowledge, de	eath occurre	ed at the time, date				way, Baltimore, MD		
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical	one) 2 Medical Examiner: On the	e basis of examination and/or anner stated.					• •			
F 3 F 8	ž	29b. Signature and title of certifier			29c. License n			29d. Date signed (M			
		Theodon W. King	& Ja, m	· ).	O.C.M.	E. (	CME	October 24, 20	10		
		<ol> <li>Name and address of person who completed the complete state of the complete</li></ol>	edcause of death (Item 23a) ssistant Medical Exan	niner 1	11 Penn Stree	et, Baltimore	MD 21201				
St	ate	31. Data filed (M2/17) 2010 Len	32. Registrar's Bignatu			,,	2.201				
Regist	rar	ULIZIZUIU LEN	wa po uga	VAL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 9 рм 20 2010 Maria Brooks Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death The Johns Hopkins Hospital Baltimore na If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F Country) Director 216-54-5484 58 6-19-195 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified one. 10a. State 10b. County 10c. City, Town or Location Baltimore 10d. Inside City Limits Director na 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1102 New Hope Circle 21205 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1xXNever Married 2 Married Completed by 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12)
12th grade College (1-4 or 5+) Assembly Worker Factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Calvin Brooks MaryE. Dunn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kendra Jones Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 10-11-2010 Balto, MD Greenmount 4 Donation 5 Other (Specify) 22. Name and Address of Facility March East F/H 21. Signature of Funeral Service Licensee 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition my o cardo Medical resulting in death) Due to ( as a consequence of) Examiner y eury Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or linjury 6 CULTS Due to for as a consequence of Exami or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Dav Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown Division of Vital Records, P.O. ò signed & Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 Yes 2 No Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? Witour Fedo 24a. Was an by usual of a on? has autopsy perform certificate 1 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 □ No မ 1 ☐ Inpatient 2 ☐ R/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town. State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0032392 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North Calvert Street Ball. MD triedmun 313 21202 MS 31. Date filed (Month, Day, Year) OCT 27 2010 32. Registrar's Signatur State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 October 0 <u>Subid Ranjan Bose</u> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 17 West End Court Baltimore Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) India 1 **⊠**M 2 □ F Months Days Hours Min. (Month Day Year) **Director** 220-68-3892 66 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Md Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17 West End Court 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 Widowed 4 X Divorced Indian traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Mac Machine Company 12 Machinist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental h ၉ Malaya Rani Bose permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any Injury or other traumatic Mohini Mohan Bose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 West End Court Maryland 21227 Mr Sinjan Bose Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 10/23/10 Baltimore, Maryland 21. Signature of Funeral Service Lide 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition h sician/ a horreas Year Medical resulting in death) Examiner an area tic Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner sician and burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Completed by Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Day Month Pregnant at time of death 1 Yes 2 No 9 Unknown P.O. sate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? perform After this certificate Yes 2 To the Hospital or Attending Physician; T within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: မှ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🛂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital Records,

DIAZ 16 50 occens 32. Registrar's Signature OCT 27 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

DHMH 17 Rev 7/2009

State

Registrar

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22,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ Georgette Juliette Burkhardt 12:35P M October 2010 Medical 4b. City, Town, or Location of Death Bel Air 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Upper Chesapeake Medical Center Harford 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days 1 □ M 2 💢 F 84 France 213-46-2325 Jan. **Director** Usual Residence of Decedent should be filed within 72 hours after death with the Maryland nand Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f shorraumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 No Maryland Harford Belcamp 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21017 Funeral 1400 Dalmation Place, Apt. T1 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 2 X No ☐ Yes White Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 XWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles George Germain Juliette (nmn) Godefroy permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4412 Sophia Way, Belcamp, Maryland 21017 19a. Informant's Name/Relationship (Type, Print) Linda Martin / Daughter Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Towson, Maryland Hilltop Service Corp.: 10-25-10 4 Donation 5 Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1317 Cokesbury Road, Abingdon, Maryland 21009 athleen 23a, Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Cardiogenic Physician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** mocardial infarction Acute Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 Georgette Juliette IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Acute renal failure 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy After this certificate has performed? Yes 2 N 1 🗌 Yes 2 🗍 No 25. Was case referred to medical 26. Place of Death (Check only one) the funeral director, æ Other: 4 Nursing Home 5 Residence 6 Other (Specify) Burkharat, 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: of or Attending Parter death.

Director: After t 1 Natural work?
1 Yes 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be within 24 hours after des To the Funeral Director completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D63420

State Registrar

upper chesapeake Dr. Bel ATT MD21014 500 Kharal 31. Date filed (Month, Day, Year) 0CT 27 2010 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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October 21,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#2operPHYS, G908, 10/27/2010, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat Physician/ L/11 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel 87 Circle Road Pasadena **Funeral** Social Security Number 6, Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🛛 M 2 □ F Days Min. Hours March 12, 1936 Connecticut **Director** 042-28-9745 Yrs Jsual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director other traumatic event, the Medical Examiner must be notified 1 Yes 2 No Anne Arundel Pasadena Maryland 5 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 23a Funeral U.S.A. 7882 B Tall Pines Court 21061 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? 1 Yes 2 No If Yes, Give Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) marked other than College (1-4 or 5+) N/A Elementary/Seconday (0-12) and Mental Hygiene. Sales Manager B.F.I. Waste Systems Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Beatrice Mead William Α. Booth 19a. Informant's Name/Relationship (Type, Print) f Health and item 27 is r 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1143 Wheatfield Drive Lake Orion, Michigan 48362 William K. Booth (Son) Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 1  $\square$  Burial 2 K Cremation 3  $\square$  Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Cremation 10/30/2010 Glen Burnie, Maryland 21. Signature of Faneral Service Licenses M2CNTF3mP6fyfildFaFilmeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on ea Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Completed 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform performed? Yes 2 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) Daughter's examiner? 1 🗌 Yes Certificate: To 2 No Other: 4 ☐ Nursing Home 5 → Sidence 6 A Other (Specify) Residence 1º Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗆 Yes 2 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29b. Signature and title of and address of person who completed cause of death 10+1 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

MDHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of D			
and agree of			627 Opel Road		Glen I	Burnie If Under 24 Hrs.	8. Date of Birth	Anne Ar	runde L  Birthplace (State or Foreign		
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. Ia	ist birtnaay) Yrs.	Months Days	Hours Min.	(Month, Day	Venul	Country) ennsylvania		
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Baltimore, Maryland 21215-0036	permit. Page 1 Department of I Important: If it any injury or or		4 □ Donation 5 □ Other (Specify) G1€  21. Signature of Funeral Service Licensee		en Mem. Pl		9/20101	Gien Buri	nie, Maryland		
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Ω̈́	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as										
	Hosp 24 hou Fune	Medical	29a. Certifier (Check only one)  1  Certifying Physician: To the best of my know 2  Medical Examiner: On the basis of examination 3  Certifying Nurse Practioner: To the best of my know 2  Medical Examiner: On the basis of examination of the basis of	n and/or inves	stigation, in my opinie	on, death occurred a	t the time, date a	and place, and due to	the cause(s) and manner stated.		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month OCTOBER Physician/ 2010 12:50A SUSAN R BLAVATT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE TOWSON GILCHRIST HOSPICE CARE 9. Birthplace (State or Foreign Country), MD Social Security Number 7. Age (In vrs. last birthday If Under 24 Hrs. 8. Date of Birth **Funeral** Min. 1 🗆 M 2 🗓 F Hours 0970371940 70 Director 220-36-8310 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No MD BALTIMORE OWINGS MILLS 10f. Zip Code 10e, Street and Number 10g, Citizen of What Country? Funeral USA 3401 NANCY ELLEN WAY 21117 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) MANUFACTURING should be filed with and Mental Hygien. PRESIDENT Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ္ဝ POMERANTZ HOWARD GLAZER LEAH permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3401 NANCY ELLEN WAY, OWINGS MILLS, MD 21117 RONALD BLAVATT / HUSBAND 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of GARRIESON Per 160 RESTER 160 Per 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 10/26/2010 | OWINGS MILLS, MD CHIZUK 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause are each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ northe disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin nding physician and use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the burnel of the state of the surface of the Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No sate has been signed by the atte page 2 should be detached for t Month Year Pregnant at time of death Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 NO 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဂ 4 Nursing Home 5 Residence 6 N Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles ST TONSUN MO

DHMH 17 Rev 7/2009

State Registrar 32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 1040P M ANNabe WSTER Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death
Baltimone Examiner COMMONS Nursing HOME ntonsville CTONSVII If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 M F Hours Month Day, Years Maryland Director Usual Residence of Decedent 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral aurens U.S.F Tree Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗓 No Black White etc ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes Give Black Completed 3 ₩ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired) 16b. Kind of Business Industry should be filed within 72 h and Mental Hygiene.
7 is marked other than "I Elementary/Seconday (0-12) College (1-4 or 5+) tousewite DOMESTIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Mary Frank Nel permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e SON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) JO ANN daughter Street Bottimore, MD owi 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Elkridge, MD -22-2010 Meadowridge Memorial Park 10 4 Donation 5 Other (Specify) 22. Name and Address of Facility Funeral 21. Signature of uneral Service Licensee Road Jessup, MI) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final lyangrang Physician/ disease or condition resulting in death) Quever Medical weeks Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? performe within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 Yes Investigation 6 Could not be Accident 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) October 20 ,2010 Cicebra a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SEE THA RAIN WD, 4367 HOMMS FENTY

Registrar

DHMH 17 Rev 7/2009

32. Registrar's Signature

Baltimore MD21297

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ RA 15 0 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SEASONS HOSPICE RANDALLSTOWN BALTIMORE If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Country) **Funeral** Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Days Hours MAY 12, Year 913 223-24-2884 1 □ M 2 😿 F 97 VA Director Yrs. Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director ANNE ARUNDEL MD GLEN BURNIE 1X Yes 2 No 0 10e. Street and Number 10g. Citizen of What Country? Funeral 703 LEE STREET 21061 USA death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ь Completed by 1 Never Married 2 Married ☐ Yes Yes, Give Page 1 and 2 should be filed within 72 hours after 2 X No Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🕱 No Specify "natural", Specify: 3 Widowed 4 Divorced BLACK Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. HOMEMAKER HOME Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surn VIRGINIA M JACKSON ၉ CALVIN H. ELLIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a WILLIAM S. COLES, JR.,/SON 13120 CHAPEL HILLS DRIVE FREDERICKSBURG, VA 22407 item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō permit, Page 1 Department of Important; If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ROSE LAWN MEMORY GRDN 10-30-2010 ASHLAND, VIRGINIA Signature of Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. Anes a. 1701-31 LAURENS ST. BALTIMORE, MD 23a P rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ REBRAL hrom bo disease or condition resulting in death) 0 ) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a d be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe Yes 2 certificate 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 | Medical Examiner: On the basis or examination array of investigation, it may opinion, seat recommendation and the cause (s) and manner as stated.

3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29b. Signature and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print)

8 3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #18 Per FH G908 10/27/10 JH State of Maryland / Department of Health and Mental Hygiene for State Registrar 33534 Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last 3. Time of Death Year Physician/ 1.48 PM 2010 10 Medical Name (if not institution, give street a 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore amaritan 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month 1 M 2 □ F Country) Yrs Director 23a or 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10c. City, Town or Location Director 1 Yes 2 No 10e. Street and Number 748 Shore Drive 10f. Zip Code 10g. Citizen of What Country? Funeral 21085 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use refired)

WARD SALES MANAGER (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) æ Father's Name (First, Middle Name (First, Middle, Maiden Surname ပ Martha Magnolia Holland 19a. Informant's Name/Belationship (Type, P 20b. Place of Disposition (Name of 20a. Method of Disposition 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Doensee Maryland 21212 NU015 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final EPSIS Physician disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or iinjury EUMO To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral inector, page 2 should be detached for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Day Year Pregnant at time of death Yes 2 □ No Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 2 PNo 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 NO မ 1 Dinpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide work's 5 Pending 2 🗌 No 1 Yes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29d, Date signed (Month, Day, Year) MEDICAL - RESIDENT 2010 10 5000 O 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOCH RAVEN BLUD, BALTIMORE, 5601 PARANTI Registrar's Signatu State Registrar

R. CAREY MARCELLUS

			Please Type or Pri				-	•	
			State	aryland / Depa	artment of H tificate of D			2010	33635
			Registrar  1. Decedent's Name (First, Middle, Last)			Calli	2. Date of Dea		3. Time of Death
4	Physicia Medic	cal		ellus Care			Month OCTOBE	Day Year R - 24 - 2010	
	Examin	er	4a. Facility Name (if not institution, give street and number)  GOOD SAMARITAN HOSP17	AL	4b. City, Town, or I			4c. County of Dea	N/A
Ė	Funeral Director		217-38-2315 1 ¼ M 2 □ F	e (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da		rthplace (State or Foreign "Waryland"
	ıryland t-f show ied at	Director	Usual Residence of Decedent  10a. State  10b. County  Maryland  N/A	10c. City, Town or Loc		ltimore			10d. Inside City Limits X 1  Yes 2 No
	ith the Ma 23a or 28a st be notii	ral Dire	10e. Street and Number 1658 Burnwood Road		10f. Zip Code	21239	T	10g. Citizen of What C	
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Morried  12. Was Decedent Armed Forces?  1 Yes 2 Mried  If Yes, Give  Year or Dates.	Nic	Vas Decedent of His Yes, specify Cuban  ☐ Yes 2 ★ No		ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:	
Baltimore, Maryland 21215-0036	within 72 hou giene. er than "natu , the Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or the second s	(Give k	ent's Usual Occupat ind of work done du O NOT use retired) Em		ing	16b. Kind of Business Rosewood	s Industry State Hospital
land	d be filed Mental Hyg arked oth	To Be	17. Father's Name (First, Middle, Last)  Unknown Davis			18. Mother's Nam		Maiden Surname) cinda Davis	
, Man	d 2 shoulk alth and N 1 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print)  Larry Bailey	19b. Mailin	g Address (Street ar	nd Number or Rura d Road Balti	al Route Number more, Mary	r, City or Town, State, Z land 21239	ip Code)
more	Page 1 an nent of He ant: If iten ıry or oth		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		sition (Name of natory or other place tus Memorial I	) !	Date 10/30/10	20c. Location - City o	r Town, State e, Maryland
Balt	permit. Departr Importa any inji		21. Signal, a of Funeral Service Licensee	22.	Name and Address Estep B 1300 Eu	of Facility rothers Fund utaw Place B	eral Service saltimore, M	, P. A. Id 21217	
4	nysician/		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition	d the death. Do not enter					Approximate Interval Between Onset and Death
	Medical Examiner	Ļ		a consequence of):	CANCER	OF L	ING		UNKNOWN
	executed ian and irial-transit	Examiner	cause. Enter Underlying Cause (Disease or riinjury that initiated events	a consequence of					
	ite be exe hysician a he burial-		resulting in death) Last Due to (or as	a consequence of):					
P.O. Box 68760	Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Per this certificate has been signed by the attending physici steed filled in by the funeral director, page 2 should be detached for use as the but the funeral director.	Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal death 3 🔲	Ectopic pregnancy Other (specify)			23d. Date of di Month	elivery Day Year
ls, P.O	uires that the signed by the signed by the details and the details.		Part II. Other significant conditions contributing to death be HIV/AID5 COPD HTN			n in Part I.		obacco use contribute t	o the cause of death?
Division of Vital Records,	sician: The law requ certificate has beer irector, page 2 shou	Completed by		,	No. 1 to		24a. Was autop	prior to death?	
ta F	cian: T ertifica ector, p	Be C	25. Was case referred to medical examiner?			ce of Death (Chec	1 🗌 Yes k only one)	2 1 No 1 1 Te	es 2 L No
<u>=</u>	Physi this c ral dire	2	1 Yes 2 No Hospital: 1 Inpati	ent 2 ER/Outpatient	t 3 DOA Other	4 L Nursing Ho		dence 6 Other (Spe	cify)
o uo	eath. or: After the funer	Certificate:	1 ✓ Natural 5 ☐ Pending (Month, Da 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be		work?		280. Describe n	ow injury occurred	
Divis	tal or Attend rs after death al Director: /		4 Homicide determined 28e. Place of Injurial building, etc.	ury - At home, farm, stre c. (Specify)	et, factory, office		28f. Location (S City or Tow	Street and Number or Ri n, State)	ural Route Number,
	the Hospital or hin 24 hours aft the Funeral Dir πpleted filled in	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of e 3 Certifying Nurse Practioner: To the	xamination and/or investi	gation, in my opinion	, death occurred a	t the time, date a	nd place, and due to the	cause(s) and manner stated.
	To the I		29b. Signature and title of certifier  MD		RES O		1	29d. Date signed (Mon	
			30. Name and address of person who completed cause of discourse of the SRITIKA THAPA, 5601 LOC			ALTIMOR	E MD	-21239	
	Stat		31. Date filed (Month, Day, Year) 32. Pegistra	ar's Signature		,	- ,		
DHM	Registra IH 17 Rev 7/20	_	OCT 27 2010 Augus	~ B. pa	uka				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Month Con :30PM 2010 Medical 4a. Facility Name (If not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death tox | If Under 24 Hrs. 8. Date of Birth | Month, Day, Year | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | No. 100 | **Funeral** 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Country) Days Months 241-46-8985 1 □ M 2 🔍 78 Yrs. Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 No Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes Baltimore, Maryland 21215-0036 1 Yes 2 Wo Specify: 3 Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname). မ 19a, Informant's Name/Relationship (Type, Print) 7109 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Termation 3 Removal from State cemetery, crematory or other place) MIC 5 Other (Specify) 4 Donation 21. Signature of Funeral Service Lice 2120 23a. Part 1. Enter the disease, or complications that caushock, or heart failure. List only one cause on part in the death. Do not enter the mode of dying, Approximate Interval Between Ofset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy signed by the atte in the past 12 months? Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of page 2 s autopsy death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical within 24 hours after death,

To the Funeral Director After this certific completed filled in by the funeral director, Certificate: To Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 0 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 5 Pending injury 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledg 29b. Signature and title of certifi and address of person who completed cause of death (Item 23a) (Type, Print), HEN W. MENUTT 2835 SHITH AVE SUITE 203 PALT (MOLE, MD 21269 Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State

Registrar

27

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 19 per FH G908 10/29/10 JH. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** James Richard Dumas 24 October 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner drs. 8. Date of Birth (Month, Day 7-7-1938) n/a Hospital Baltimore Baltimore 01 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** M 2□F 72 512-40-5469 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Everning must be retified at once. 10d. Inside City Limits 10h County 10c. City, Town or Location 10a. State 1X Yes 2 □ No **Funeral Director** Baltimore MD n/a 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21215 USA 5915 Key Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 📉 No Specify: African-American Baltimore, Maryland 21215-0036 Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Defense Intelligence United States Army 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Asoler McQiller Will Kirby ၀ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print)
Charlotte N. D.mas/ Wife 5915 Key Avenue, Baltimore, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Veterans 11-4-2010 Owings Mills, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility While Fineral Hone F.A. of Balto. Co. Signature Funeral Servige Licenses 9200 Liberty Road, Randallstown, MD 21133 23a. Part/. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestive **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner schemic Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit the death certificate be executed Due to (or as a consequence of) Division of Vital Rec6rds, P.O. Box 68760 Physician/Medical attending p as IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 1 □ Yes 2 □ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) certificate has been signed by rector, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 **W**No Certification: To 28b. Time of 28d. Describe how injury occurred Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 24 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital of Baltimore m.D. 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Physician MAD 17A 26 Octobor 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Social Security Number **Funeral** Days 1**X** M 2 □ F Months 60 Director 50 219-86-1321 Usual Residence of Decedent Lebanon Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 Yes X No Director Lauderdale FL10g. Citizen of What Country? 10e. Street and Number U.S.A. 33301 616 Riviera Isle Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10yrs 12th grade American Radiology Radiologist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ Radiya Fakhri Aref Fakhri 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health Important: If item 27 any injury or other troonce. 2365 Boston Street, Baltimore, Md 21224
ce of Disposition (Name of Date 20c. Location - City or Town, State Ali Bydon-Son-In-Law 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) K Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) <u>Fakhir Village 10/30/2010 Beirut, Lebanon</u> of Funeral Service Licensee 22. Name and Address of Facility March F/H West Baltimore, Md 21215 4300 Wabash Ave, 23a. Part 1. Enter the disease, or complications that collised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that initiated events resulting in death) Last The law requires that the death certificate be executed ysician and the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Z No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide

Box 68760. PO. of Vital Records. or Attending Physician: Division after death completely filled in by the Hospital within 2 To the F

> State Registrar

DHMH 17 Rev 1/2001

Medical

29a. Certifier

(check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) idno 32. Registra

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

October 26, 2010

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES - 000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Lattrell Ann Geter State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Lattrell Ann Geter—Thurman 2. Date of Death 3. Time of Death Physician/ 0225 hrs Medical Examiner Latrell Ann Cotor October 17, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Security Blvd & West Perimeter Drive Woodlawn **Baltimore County** If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24Hrs 8. Date of Birth (MM/DD/YYY) **Funeral** Months Days Hours Director 213-13-5600 29,198 2 X F Country) MD 1 M 27 Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d, Inside City Limits MD N/A 1 X XYes 2 No or 28a-f show Baltimore , or items 23a or 28a-f shov r must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1212 Turpin Lane 21202 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 X Married Itimore, MD 21215-0036
it. Pages I and 2 should be filed within 72 hours after deal runent of Health and Mental Hygiene. 2 X No Yes 1 Yes 2 X No specify. 3 Widowed 4 Divorced f Yes, Give Year event, the Medical Examiner Specify: Black ğ 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 1 year Car Rental Assistant Russell Toyota 17. Father's Name (First, Middle, Last 18 Mother's Name (First, Middle, Maiden Surname) Be Marilyn Peele Tyrone Geter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is m Marilyn Geter/ Mother 1212 Turpin Lane Baltimore, MD 21202 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State King Memorial Park 10/22/10 Woodlawn, MD mportant: 4 Donation 5 Other Specify 21. Signature of Funeral Service License 22. Name and Address of Facility Chatman-Harris Funeral Home 4210 Belair Road Baltimore, MD 21206 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and livedical a. Multiple Injuries Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and or use as the burial - transit Physician/Medical X AMENDED #1perME, G909, 11/16/2010, WS UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Ectopic pregnancy Month Year Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) has been signed by the att 2 should be detached for 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? page certificate ✓ Yes 2 No 1 🗸 Yes 2 No director, 26.Place of Death (Check only one) l or Attending Physician: after death. 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient Other<sub>4</sub> DOA Nursing Home 5 Residence 6 Other: Scene this 2 ER/Outpatient 3 1 🗸 Yes After 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Oct 17, 2010 Year) Ejected passenger in motor vehicle-fixed object Natural Pending 1 Yes 2 V No Director: d in by the f collision 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Fo the Hosp...
within 24 hours after the Funeral D Suicide or Town, State) Security Blvd & W Perimeter Dr, Woodlawn, MD determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 17, 2010 Caral 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner #11 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Level Degistres Sign

			_ For State of	of Marylan	id / Dep	artment of I	Health and	l Mental Hy	/giene	
			1 - State Registrar		$C\epsilon$	ertificate of	Death		Reg. No 2 0   (	33540
Ī	Physici	an	1. Decedent's Name (First, Middle, Last)  MARIE C. GNA	ATOWSKI	[			2. Date of De Month	Day Yea	3. Time of Death
· Arabi	/Medic Examin		4a. Facility Name (If not institution, give street and nu			4h City Town o	or Location of Dea	1 0	25 2016 4c. County of De	
1	Examin	er	FRANKLIN Square	Hospit	01		edale		-	imode
	Funeral		Social Security Number 6. Sex	7. Age (In yrs.	last birthday		If Under 24 Hi	s. 8. Date of Bi	th O B	irthplace (State or Foreign Country)
	Director		213 26 6865 1 M 2 KF	8	O Yrs.	Wonths Days	Hours Min	3/30/	1930 MA	RYLAND
	and w		Usual Residence of Decedent  10a. State 10b. County	10c Cif	y, Town or L	ocation				10d. Inside City Limits
	Maryli f sho	jo	MD BALTIMORE		SEDAI					1 ∐Yes 2X No
	r 28a	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of What (	Country?
	h with	al D	2301 HOLYOKE ROAD			2123	7		USA	Δ
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Madeal Eventhar must be naithed at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Dec Armed For I Yes If Yes, Giryear or Dec Year  2 No ive No	S. 13.	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☐ No		(Specify Yes or No erto Rican, etc.)	14. Race - Ar Black, Wh Specify:	nerican Indian, lite, etc. WHITE	
20	72 hou	ted	15. Decedent's Education (Specify only highest grade completed)		16a. Dec	edent's Usual Occup	pation		16b. Kind of Busines	s/Industry
21	ithin 7	Completed	Elementary/Secondary (0-12) College (		life.	e kind of work done DO NOT use retire	d)			
2	led w lygier her tl	Ö	12 0		SWIT	CHBOARD			MARTI	INS
Maryland	ld be fi lental P ked ot ic ever	To Be	17. Father's Name (First, Middle, Last)  Joseph Niedzwic	k			Cathe:		Pollack	
ary	2 should and Mer is marke aumatic		19a. Informant's Name/Relationship (Type. Print)		19b. Mail	ing Address (Street	and Number or I	Rural Route Numb	per, City or Town, State	, Zip Code)
	and 2 Health m 27 i		MARK GNATOWSKI/SON					JARRET	TSVILLE,	
altimore,	Pages 1 nent of H int: If Iter iry or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from	Siale		osition (Name of matory or other pla		Date	20c. Location - City of	
<u>=</u>	it. Pai rtmen rtant: njury		4 ☐ Donation 5 ☐ Other (Specify)	НОІ		SARY CEN		29/10	BALTIMOR	
Ba	permit. Departr Importa any Injt		21. Signature of Fureral Sprice Licensee			211 CHE	SACO A	VE BALT	IMORE, MI	NERAL HOME 21237
	Physician /Medical Examiner		resulting in death)	caused the death each line.  (or as a consequence	l Car	rcincus		rai Ca		Approximate Interval Between Onset and Death
	ficate be executed physician and s the burial-transit	al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	(or as a consequ			_			
687	ficate p phys s the	edical	d							
O. Box		by Physician/Me	in the past 12 morths?	tcome of pregna birth 2 ☐ Feta inant at time of d nown	I death 3	☐ Ectopic pregnand	Ç <b>y</b>		23d. Date of c Month	delivery Day Year
Records, P.	ires that signed by		Part II. Other significant conditions contributing to d	eath but not resu	ulting in the I	underlying cause giv	ven in Part I.	23e. Did	tobacco use contribute	to the cause of death?  Probably 4  Unknown
S	w requir been s should	etec						24a. Was		
_	sician: The law certificate has tirector, page 2 s	e Completed	25. Was case referred to medical				OC Place of D	auto perfo 1 ☐ Yes	psy prior t ormed? death 2 No 1 Ye	autopsy findings available o completion of cause of ? es 2 □No
	Physician: r this certificanal director, promote in the contractor, promote in the contractor, promote in the contractor	o Be	examiner?	Inpatient 2 🗆	ER/Outpatie	ent 3 DOA Oth	or:	eath <i>(Check only c</i> Home 5 □ Resi	idence 6 ☐ Other (Si	necify)
0	neral	Ë	27. Manner Death 28a. Date		28b. Time o	of 28c. Inju	ry at		how injury occurred	,
000	Attending Phys r death. ector: After this by the funeral dir	atic	2 Accident investigation	, ,			Yes 2□No			
Division of	l or Att after de Direct I in by 1	Certification: To	3 Suicide 6 Could not be determined 28e. Place buildi	of Injury - At hoing, etc. (Specif	ome, farm, st	reet, factory, office			'Street and Number or wn, State)	Rural Route Number,
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifies (Check daily one)	e best of my kno casis of examina ner stated.	wledge, dea tion and/or i	th occurred at the tinvestigation, in my	me, date and pla opinion, death oc	ce, and due to the curred at the time	e cause(s) and manner , date and place, and d	as stated. ue to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed (Mo	nth, Day, Year)
				in. D.		3	45391	) (	October 2	6th. 2010
			30. Name and address of person who completed cause Min (h.D.) 9(14)	se of death (Item	23a) (Type	Print) and =	#208,	Saltin	nose, M	021237
Ī	Sta Registra			Registrar's Signa		1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760 completely filled in by the funeral director, within 24 hours a To the Funeral I

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) State 27 2010

29b. Signature and title of certifier

M. Eletta Morse CRNP, 2434W. Belvedera Dee, Baltymore MD 21215 32. Registrar's Signature

Le Namouse CENP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R070440 MD 10/25/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 4:19 AM Physician/ Hardy Howard Goodson 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 638 East 37th Street <u>Baltimore</u> If Under 1 Year If Under 24 Hrs Months Days Hours Min. Social Security Numbe . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral №** 2 □ F Months 12-7-1924 Country) 85 Director S.C 250**-**22-8818 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 XYes 2 No MD na Baltimore 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Funeral items 23a 638 East 37th Street 21218 USA 12. Was Decedent Ever in U.S. 13, Was Decedent of Hispanic Origin? (Specify Yes or No 14 Race - American Indian. 11. Marital Status Armed Forces?

Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married "natural", or ģ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3

Widowed 4 □ Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 i
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ns
any injury or other traumatic event (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Wyman Park Hosp Elementary/Seconday (0-12) 12th grade Chef Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Goodson Lila Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Roach-Daughter 638 E. 37th Street Balto,MD\_ 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Greenmount 1 ☐ Burial XXCremation 3 ☐ Removal from State 10-29-201d Balto, MD 4 Donation 5 Other (Specify) 21. Signature of Fundal Service Licensee 22. Name and Address of Facility March East F/H Balto, MD 21202 1101 Ε. North Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atherosilerotic Biscase Physician/ Cardiovasula disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Esquentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year 1 Yes 2 No detached After this certificate has been signed by a funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of SIP LVA 24a. Was an autopsy death? performed Vasurlar 1 🗌 Yes 2 🗌 No 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 은 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation after death Director: / completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the l within 2 To the l only one) 29d. Date signed (Month, Day, Year) Belsome und 2010 R110361 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) wich Raven Bl vd 3900 Whon 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

**ORIGINAL** 

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month OCT ouise 5-25 PM Medical 4b. City, Town, or Location of Death **Examiner** 4a. Facility Name (if not institution, give street and number, 4c. County of Death 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Min Director "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Kes 2 No timore 10g. Citizen of What Country? Funeral ·Charles Street (JSA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married ould be filed within 72 hours after on Mental Hygiene.

marked other than "natural", or 1 Yes 2 No 1 Tes 2 To Specify: 3 Divorced Year or Dates permit, Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Seconday, (0-12) College (1-4 or 5+) Be 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 21. Signatule of Fureral Service Licensee 110155 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DISEASE ORONARY hysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Due to (or de a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 4 Pregnant a Day Month Pregnant at time of death 5 Other (specify) Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by OF STROKE 1 Yes 2 No 3 Probably 4 1 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No HYPERTENSION 24a. Was an autopsy performed? Yes 2 No END STAGE RENAL DISEASE Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 X No မှ 1 XInpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending 1 X Natural 2 Accident
3 Suicide Investigation within 24 hours after death

To the Funeral Director:
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10063327 H- WOWETHOT Oct. 25, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2434 W. BELVEDERE AVE, BALTIMORE, MD WULDETHIWOT, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 27 2010 Registrar

news as

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician/ 12:10 PM Sharon K. Grim October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospital Baltimore Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year, 8/29,2010 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Months Hours 1 □ M 2 🗶 F 214-84-4456 48 Germany Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 🗆 Yes 2XX No Maryland Anne Arundel Curtis Bay 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 4106 Fair Haven Ave. 21061 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes. Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. Do NQT use retired)
Sales Associate 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Lowes Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward Schollian Hanni Burch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4106 Fair Haven Ave., Curtis Bay, Maryland, 21061 Robert Grim / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 👿 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/11/2010 Glen Burnie, Maryland Atlantic Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gary L. Kaufman Funeral Home, Inc. 7250 Washington Blvd., Elkridge, Maryland.21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Incephalo pathi Pnysician Hapatic disease or condition Medical resulting in death) Due to (or as a consequence of Examiner disease stage Sequentially list conditions, Examiner th (or as a con equence of): cause. Enter Underlying Cause (Disease or iinjury Sepsis requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical infection HIV Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Pregnant at time of death 1 Yes 2 9 Unknown 2 🗌 No signed by the a Id be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hepatitis 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown been s COPP 24b. Were autopsy findings available 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has t completed filled in by the funeral director, page 2 si prior to completion of cause of death? performed? disorder Scizure 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No 1 X Inpatient 2 - ER/Outpatient 3 - DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 9th 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hanover So. 3001 South 21225 Baltimore 32. Registrar's signature State Registrar

DHMH 17 Rev 7/2009

			Flease	type or Print in				_	-	Jibie.
			For	State of Marylar	•			Mental Hy	ygiene	10 0001
			1 - State Registrar		Cer	tificate of D	Death		Reg. No. 2	110 3354
			1. Decedent's Name (First, Middle, Last	)				2. Date of D		3. Time of Death
	Physicia Medic		Donna M	Grogan				Month 10	23 2	.0 <sup>Year</sup> 8:25 <sup>А</sup> м
	Examin		4a. Facility Name (if not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. Count	y of Death
			325 Crescendo Way			Silver	Spring		Mont	gomery
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. I	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of B	irth	9. Birthplace (State or Foreign
	Director		296-38-5407	<sup>M 2 ← F</sup> 67	Yrs.	Months Days	Hours Min.	12	21 1942	Country) OH
	ow L	ι.	Usual Residence of Decedent  10a, State 10b, County	140-00	~					1011 11 01 11 11
	yland f sh	댱	Toa. State	10c. Cit	y, Town or Loc					10d. Inside City Limits
	28a Dotifi	ire	MD Montgome	ry	Silver	Spring				1 🖾 Yes 2 □ No
	h the Sa or be r	a	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country?
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at	Funeral Director	325 Crescendo Wa			20901			USA	
	deat r iter		11. Marital Status	12. Was Decedent Ever in U. Armed Forces? 1  Yes 2 No	S. 13. W	as Decedent of His Yes, specify Cubar	spanic Origin? (Span, Mexican, Puerto	ecify Yes or No Rican, etc.)		ce - American Indian, ck. White, etc.
36	after I", or xami	d b	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	If Yes, Give	1	☐ Yes 2X No	Specify:		Specify	n1 - 1
8	ours attura	že	15. Decedent's Ed	Year or Dates.	10 Door					
<u> </u>	72 ho n "na ledio	gu	(Specify only highest grad		(Give k	ent's Usual Occupa ind of work done d ONOT use retired)	ation Juring most of work	ing	16b. Kind of E	Business Industry
12	within giene. <b>ner tha</b> i	Completed by	Elementary/Seconday (0-12)	College (1-4 or 5+) 5+	Teac	,			DCPS	
9	ਕੁ≑ਵ	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle	Maiden Surnam	el
an	be fill ental ked c	ျ	Rev. Donald E. Ham	ilton			Yvonne W		, maraon oannan	-,
₹	should be file and Mental F is marked o raumatic eve		19a. Informant's Name/Relationship (Type		10h Mailin	a Addrago (Stroot o	and Number or Run		or City or Town	State Zin Code)
$\mathbf{z}$	1 and 2 should be file of Health and Mental F f item 27 is marked o r other traumatic eve		De'Ana Dow/Sister	55, 1 1113	1	,	and Number of Hun ≥ Way Gai			
ē,	and Hea <b>tem</b>		20a. Method of Disposition	20b. F	Place of Dispos	sition (Name of	Ť	Date		- City or Town, State
JO L	age 1 ent of rt: If i		1 🔀 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	e) ne. 10/2	9/2010	i .			
Baltimore, Maryland 21215-0036	permit. Page 1: Department of F Important: If it any injury or of	1	21. Si nati re of Funeral Service License							neral Home
Ba	perr Dep Imp any	5 8	the for the				St. NW Wa			
	Physician Medical Examiner	0.000	23a bart 1. Enter the disease, or comp shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	lications that caused the deat e cause on each line.  a. Metastatic  Due to (or as a consequence)	Breast			or respiratory a	urrest,	Approximate Interval Between Onset and Death years
7A	s be executed ysician and e burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	b. Due to (or as a consequence.  Due to (or as a consequence)	·					
09	ate b ohysi the b			d						
Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate L within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the total the completed filled in by the funeral director, page 2 should be detached for use as the total the completed filled in by the funeral director, page 2 should be detached for use as the total the completed filled in by the funeral director.	Physician/Med	IF FEMALE: 23b, Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of a 9 ☐ Unknown	al death 3 🗌	Ectopic pregnancy Other (specify)	у			ate of delivery onth Day Year
P.0.	nat th ed by detac		Part II. Other significant conditions co	ntributing to death but not res	ulting in the ur	derlying cause give	en in Part I.	23e. Did	tobacco use conf	tribute to the cause of death?
S, F	signe d be	d by						1 🗆	Yes 2 No	3 ☐ Probably 4 ☐ Unknown
ğ	requi	lete						24a. Was	24h	Were autopsy findings available
200	has law	Completed						auto	opsy formad?	prior to completion of cause of
č	t The icate r, pag		05 Wes and the state of the sta					1 L Yes	2 No	1 Yes 2 No
ţa	ician sertif ecto	Be	25. Was case referred to medical examiner?  1  Yes 2 No	lospital:		Tothe	ce of Death (Chec			
<b>\$</b>	Phys this	<u>۔</u> 1	27, Manner of Death	1 Inpatient 2 28a. Date of injury	ER/Outpatient 28b. Time of	3 LI DOA	4 L Nursing Ho		idence 6 Oth	
n 0	ding h. After funel	ate	1 X Natural 5 ☐ Pending	(Month, Day, Year)	injury	28c. Injury work	Yes 2 □ No	28d. Describe	how injury occur	red
Division of Vital Records,	or Atten ifter deat birector: in by the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify			103 2 110		(Street and Numb wn, State)	er or Rural Route Number,
Ω	<b>Hospital</b> 4 hours ε iuneral I ed filled	Medical (	29a. Certifier 1 X Certifying Physi (Check 2 D Medical Examin	cian: To the best of my know er: On the basis of examination	edge, death o	ccured at the time,	date and place, an	d due to the c	ause(s) and mann	ner as stated. te to the cause(s) and manner state
	the hin 2, the F	Me	only one) 3 Certifying Nurse	Practioner: To the best of m		eath occurred at the	time, date and place		he cause(s) and m	anner as stated.
	<b>10</b> wit	(	29b. Signature and title of certifier			29c. License		,	_	d (Month, Day, Year)
			1 im	fulr		147	32164	′	(E)~	25=2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ari D Fishman, MD 5530 Wisconsin Avenue Suite 1125 Chevy Chase, MD 20815 31. Date filed (Month, Day, Year)

Registrar

32. Registrar's Signature OCT 27 2010

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

Private Family 18. Mother's Name (First, Middle, Maiden Surname) Bertha Walton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5513 Sagra RD. Baltimore, MD 21239 20c. Location - City or Town, State 10/25/10 Monkton, MD 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, MD 21215 Approximate Interval Between Onset and Death pulmonan years 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 6095 Marshall on Febridso, Md. 21075 CRUS 32. Registrar's Signature **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

25 am

10d. Inside City Limits

1 Yes 2 No

20105

4c. County of Death

10g Citizen of What Country?

14. Race - American Indian,

Black, White, etc.

Specify: Black

16b. Kind of Business/Industry

USA

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: After t 24 hours after death Puneral Director: To the

> State Registrar

Medical

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

6 ☐ Could not be

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. U Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 20 Carter Holloman 2010 <u>Elizabeth</u> /Medical City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** ionk timore 0 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 😾 F 230-28-2966 Director 84 VA Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Menial Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expression and by purified at once. 10a. State 10b. County X□Yes 2□No NA Baltimore Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 U.S.A. 3800 Boarman Ave 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married □Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify Black Specify Completed by 3℃ Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hospital Nurse 12th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Virginia Bell မ George Carter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 213 Longview Drive, Smithfield, NC, 27577 Robert Morris-Son Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State □ Donation 5 □ Other (Specify) Garrison Forest Vet10/28/2010 Owings Mills, Md 22. Name and Address of Facility
March F/H West erof Funeral Service License 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onsettand Death 23a. Part 1. Enter the disease, or complications that caused the shock, or healt millure. List only one cause on each line. Immediate Cause (Final sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** disease or condition resulting in death) /Medical Due to (or as a consequent of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was and autopsy performed?
Yes 2 No page certificate 2 □No 1 □Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1∭AYes 2∐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA 1 🔲 Inpatient Certification: To After this Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and the of certific 29c. License number 26. 200

State Registrar 30. Name and address of person who

27

31. Date filed (Month, Day, Year)

Franke

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Mospite1

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33648 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>010</u> Physician/ Month Henry Edward Hess АМ 4:05 October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County Baltimore The Gilchrist Center Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 21 9. Birthplace (State or Foreign **Funeral** 1**X**□ M 2 □ F Months Days Hours Mary Land **Director** 212-32-7373 75 May Usual Residence of Decedent or 28a-f show notified at 10a. State 10b, County 10c, City, Town or Location with the Maryland 10d Inside City Limits Director 1 Yes 2X No Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a or Funeral USA 21234 8600 Midi Avenue permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married by 2 No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Specify: Completed 3 X Widowed 4 □ Divorced White Year or Dates. 1954-1958 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore County, 12 N/A Police Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Elizabeth Jasper Hall Edward Hess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8807 Ashford Road Baltimore Maryland 21234 Elizabeth A. Besold (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place. Date 20c. Location - City or Town, State 1 🗆 Burial 2) Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) October 25 Baltimore, Maryland Metro Crematory Inc 21. Signatule of Funeral Service Incensee 22. Name and Address of Facility 21236 nother 7401 Belair Road Baltimore assahn Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine Due to or as a consequence of if any leading to immedi cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of) nding physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy signed by the atte in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Dav Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence Other (Specify) Hospital 2 X No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 I DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of De th 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at After Natural 5 Pending 24 hours after death. Funeral Director: Al 1 ☐ Yes 2 ☐ No Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a, Certifier 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 3 29b. Signature and title of certifier 29c. License number 23 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOCHO NY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

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State of Maryland / Department of Health and Mental Hygiene

		1-For State Registrar Registrar	J										
Physicia	an/	1. Decedent's Name (First, Middle,Last)  2. Date of Death  Month  Day  Year											
Medical Exami	ner	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death											
		8919 Waltham Woods Road Apt. F Parkville Baltimore County											
Funeral Director		5. Social Security Number 6. Sex 1 Months Days Hours Min. 7. Age (In yrs. last birthday) 1 Months Days Hours Min. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MA	_										
nd show any se.	Ļ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No.											
n with the Maryland ms 23a or 28a-f show be notified at once.	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?  3919 Waltham Woods Rd. Apt. F 2034  USA											
72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho al Examiner must be notified at once	Funeral	11. Mgrital Status 1											
urs afte tural",	۾	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify UU U  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry											
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	Be	13. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Majden Syrname)  Alice Faye Havoy  19a., Informant's Name/Relation by (Type, Print)  19b. Mailing Address (Street and Number or Ryral oute Number, City or Town., State, Zip Code)											
MD and 2 sho alth and 27 is aumati	유	Alice Fay Hurdy Mother 1931 & Latayette Ave. Rother. Md. 21218  20a. Method of Disposition   20b. Place of Disposition (Name of cemetery)   Date   20c. Location City or Town, State											
Baltimore, permit. Pages 1 an Department of He. Important: If ite		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:  21. Sign rure of Funeral Service Licensee  22. Name and Address of Facility  23. Name and Address of Facility  24. Name and Address of Facility  25. Name and Address of Facility  26. Name and Address of Facility	_										
	4	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the shode of dying, such as cardiac or respiratory arrest, shock, or heart  Approximate Interva	al .										
Physician /Medical- Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease a Complications of sickle cell disease Death											
		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.											
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last  Due to (or as a consequence of):  Due to (or as a consequence of):											
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760, cate be execut physician and the burial - trai	Medica	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	_										
Box 6876 he death certifical the attending phe	Physician/N	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 V Unknown  1 Ves 2 No 9 V Unknown  23c. If yes, outcome or pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (Specify)  9 Unknown	Ų										
ires that the de signed by the	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?											
ds, Fraguires I	ted t	1 Yes 2 No 3 Probably 4 Unknown  24a. Was an 24b. Were autopsy findings available	e										
Record The law re	Completed	autopsy prior to completion of cause of death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No											
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n of ling Ph After th	tion: To	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No											
Divisi Divisi outs after de eral Direct	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)											
Division  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
L 2 L 2	Ň	29b. Signature and title of certifier  29c. License number  O.C.M.E.  29d. Date signed (Month, Day, Year)  October 19, 2010											
Ф		30. Name and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201											
	ate	31. Date filed (Month, Day, Year)  32. Registrar's Signature											
Regist	_	UCI 27 2010 Renter B. Sall	۷										
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death L Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jackson 2010 Medical Svlvester 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 4303 Fairfax Road If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Days Hours 1**X**□ M 2 □ F Director 212-32-8912 06 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 🎦 Yes 2 □ No Baltimore NA MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ò Funeral with 23a U.S.A. 21216 <u>4303 Fairfax Road</u> items ; 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. o, 1 Never Married 2 Married 1 Yes Completed by 2 X No Maryland 21215-0036 1 Yes 2X No Specify: Specify: Black than "natural", 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City 7th grade Laborer and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Hattie Jackson <u>Matthews Wright</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) er nit. Page 1 and 2 st er artment of Health a mr ortant: If item 27 is ny injury or other tra Baltimore, Md 21216 Fairfax Road, 4303 Quandra Horton-Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/29/20**1**0 Woodlawn, Memorial Park King Signature of Funeral Service Licenses 22. Name and Address of March F/H West 21215 4300 Wabash Baltimore, Ave, 3a. Part /. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratish. k, or heart failure. List only one cause of the disease of the death. Approximate Imm diate Cause (Final Physician/ disease or condition resulting in death) Medical as a cons uence of Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) Day Pregnant at time of death 2 🗌 No signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use combute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes page 2 should 245. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas performe 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, To Be 25. Was case referred to predical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 12 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manne of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Lilatural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year)

Registrar

State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10c Per FH G908 10/27/10 Jh State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 1144A M Physician 2010 Xtouef /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 8-5-1950 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 60 1 M 2 F 219-52-6819 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No **Funeral Director** MI Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code ò 6619 23a 21207 Coad Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 Yes 2 If Yes, Give 1 Never Married 2 Married 2 No 2 No Baltimore, Maryland 21215-0036 ò 1 Tes Specify Specify: <u>م</u> Black 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) other than arc 150na Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be is marked of 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau once. timore. MI) 21207 Vethod of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cerhetery, cremator or other place 1timore 4 Donation 5 Other (Specify) 22. Name and Address of Facility Va volm 21. Signature of Funeral Service Lice Randall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, sure shock, or he death. List only on cause on each line. Approximate Interval Between Onset and Death as car cor respiratory arrest Immediate Cause (Final **Physician** PSIS disease or condition resulting in death) //Medical Due to (or as a consequence of) **Examiner** lostridium Difficile Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 TEctopic pregnancy Live birth 2 Fetal death Year in the past 12 months? Month Day page 2 should be detached for Pregnant at time of death 5 Other (specify) Yes 2 🗀 No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ of Vital Records. 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No 1 ☐ Yes 2 ☐ No Physician: completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred or Attending P s after death. Director: After t Certification: 1 Natural 5 Pending investigation Injury Division 1 Yes 2 🗌 No 2 Accident 3 Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. To the within 2 To the I 29d. Date signed (Month, Day, Year) 29c. Jacense number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 600 North Wolfe St, Baltimore, MD, 21287 Warga 31. Date filed (Nonth, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Physician/ Medical **Examiner** 8. Date of Birth Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 1 **X** M 2 □ F Director Jan permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, 10d. Inside City Limits **Funeral Director** 1 Yes 2 No 10f. Zip Code 20622 12. Was Decedent Ever in U.S. Armed Forces?

1 
✓ Yes 2 
No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 M No Specify: 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industr (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State Fores 11-3-2010 4 Donation 5 Other (Specify) Signature of Funeral Service Ligensee 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ CARDIONE SPINATORY ARREST disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner RESPIRA TORY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of, To the Funeral Director: After this certificale has been signed by the attending physician and completed filled in by the funeral director, p. ge 2 should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last SMOKING Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: T e law within 24 hours after death.
To the Funeral Director: After this certifica e has t autopsy performed 2 1 No 1 🗌 Yes Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) of Vital æ examiner? 2 🖪 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide 5 Pending work? Division 2 🗌 No Investigation JAMES 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier redem 69683 MD 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Iw.

27

31. Date filed (Month, Day, Year)

MAGNI

2. Registrar's Signature

LEONARD TOWN MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October MELVIN 2010 11:40 PM Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford 713 Royal Mile Drive Abingdon Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland Min. (Month, Day, Year) 1 🛛 M 2 🗆 F Hours Director 941 220-36-9579 68 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 21009 USA 713 Royal Mile Drive 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Armed Forces? 1 X Yes 2 ☐ No Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give Specify: White "natural" 3 ☐ Widowed 4 ☐ Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene tant: If item 27 is marked other than 'iury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Administrator Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul Joseph Jeffers Gladys Mae Stagge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 713 Royal Mile Drive, Abingdon, Maryland, 21009 Janet Jeffers / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date XBurial 2 ☐ Grema Important: It any injury or 4 Donation Other (Specify) Druid Ridge Cemetery 10/25/2010 Baltimore, Maryland 21. Siz ure of Full al S 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enter the disease, or compleations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PROSTATE CANCER WITH BONE METS Physician disease or condition resulting in death) years Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if at y, leading to immedia cause. Enter Underlying Cause (Disease or linjury Due to (or se's consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 2 No g Unknown g | Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by completed filled in by the funeral director, page 2 should be 2 No 1 🗌 Yes 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{ Yes} \) 2 \( \subseteq \text{ No} \) 24a. Was an certificate has autopsy Yes 2 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Cother (Specify) After this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 5 Pending Accident Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗖 within 2 To the I only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) HEMATOLOGIST, 10/22 MD D-51555 12010 ONCOLOGIS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

SEIN AUNG.

31. Date filed (Month, Day, Year)

27 2010

9103

32. Registrar's Signatur

FRANKLIN SOUPREDRIVE #2200, BALTIMORE, MD 21237

10-08104

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Richard Arland J		otato or maryiana.	rtment of Health an				3365L	
		Registrar	tificate of Death		Reg	. No.	3. Time of Death	
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last)			Month Cotober 22,	Day Year 2010	2319 hrs	
		Richard Arland Jackson  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or	Location of Death		4c. County of Death		
		St. Mary's Hospital	Leonardtow			St. Mary's		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la	st birthday) If Under 1 Yea  Months Day		-	(MM/DD/YYYY) 9. Birt Foreig	n	
Director		215-27-6862 1XM 2F 20	Yrs.	3 Flours Willi.	02/09/	1990 Co	untry) DC	
any		Usual Residence of Decedent  10a, State 10b, County 10c, City,	Town or Location				10d. Inside City Limits	
10 W 31		MD Prince George's	Bowie				1 Yes 2 No	
arylan sa-f sl	Director	10e. Street and Number	10f. Zip Code		100	j. Citizen of What Cour	itry?	
the M	Dire	3914 Ettrick Court	20716			USA		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	eral	11. Marital Status 12. Was Decedent Ever in U.S				14. Race - Ameri White, etc.	can indian, Black,	
death or ite	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No			Ricari, etc.)		1	
s after ral",	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No		work done	Specify: B1a		
? hour "natu Exan	ted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	during most of working life			IOD. KING OF BUSINESS/I	idustry	
336 thin 72 re. than	Completed	2years		Mr. Tire				
5-0036 iled within 72 Hygiene. I other than	Con	17. Father's Name (First, Middle, Last)		18.Mother's Name	(First, Middle, Ma	aiden Surname)		
2121; ould be fill Mental F. marked	Be	Gary Spencer Scales				eth Jackson		
D 2. Should md M	7	19a. Informant's Name/Relationship (Type, Print) mother	19b. Mailing Address (Stree 3914 Ettrick				Zip Code)	
, MD and 2 sho ealth and em 27 is		Margaret Elizabeth Jackson/ 20a,Method of Disposition 20b. P	lace of Disposition (Name of cer			20c. Location - City or	Town, State	
Baltimore, pernit. Pages I ar Department of Hee Important: If ite		1 Burial 2 Cremation 3 Removal from State	rematory or other place)	0 10/	00/0010	Cuitland 1	4TD	
Itim it. Pa urtmen ortant		4 Donation 5 Other Specify: L1n 21 Signature of Funeral Service Licensee	coln Memorial	s of Facility Man	29/2010  rehall-M	arch Funera	1 Home	
Ba perm Deps Imp		to to Indeed	4217 9th S				ii nome	
Physician	П	23a. Part I. Enter the disease, or complications that caused the death. failure. List only one cause on each line.	Do not enter the mode of dying,	, such as cardiac o	r respiratory arres	t, shock, or heart	Approximate Interval Between Onset and	
/Medical Examiner		Immediate Cause (Final disease a, Multiple Injuries					Death	
- A		or condition resulting in death)  Due to (or as a consequence of)	):					
	e	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of)	);					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated						
unsit te d'	Exa	events resulting in death) Last  Due to (or as a consequence of)  d.	:					
executed ian and ial - transit	ical	UNPENDED AMENDED	· ·					
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be After this certificate has been signed by the attending physici funeral director, page 2 should be detached for use as the buri	cian/Med	IF FEMALE: 23c. If yes, outcome of pregn	ancy			23d. Date of delivery	L	
687 certific	ian/	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3	Ectopic pregna	ncy	cy Month Day		
Box e death c the atten	Physic	1 Yes 2 No 9 Unknown 9 Unknown	other (Specify)					
O. E hat the ed by the letached		Part II. Other significant conditions contributing to death but not re-	sulting in the underlying cause of	given in Part I.		acco use contribute to	the cause of death?	
ires th signed	d by				1 Yes	2 No 3 Prob	ably 4 Unknown	
rds v requi	lete				24a. Was an autopsy		opsy findings available ompletion of cause of	
of Vital Records, ig Physician: The law requir witer this certificate has been somed director, page 2 should layer.	Completed				perform 1 Yes 2	ned? death? ☐ No 1 ✔ Ye	s 2 No	
al R ian: T certific	Be C	25. Was case referred to medical examiner?		of Death (Check	only one)			
Vit.		1 ✓ Yes 2 No	Zito dipationi o Bost			esidence 6 Other		
n of ding P After funeri	on:	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day Year) Oct 22, 2010	00001	ry at Work? Yes 2 ✔ No	28d. Describe no Pedestrian st	w injury occurred ruck by auto		
Division tal or Attendi as after death.	Certification:	2 Accident Investigation	me, farm, street, factory, office b		28f Location (Str	eet and Number or Ru	ral Route Number. City	
Divi	ite) reek Road, Mechan							
Division of Vital   To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director.	S =	4 Homicide determined (Specify) Major Road  29a. Certifier 1 Certifying Physician: To the best of my knowledg						
o the I ithin 2 o the I	Medical	one) 2 Medical Examiner: On the basis of examination an and manner stated.						
E & E 8	Me	29b. Signature and title of certifier	29c. Licens			29d. Date signed (Mor		
		D_M L-	O.C.	M.E.		October 23, 2010	)	
5		30. Name and address of person who completed cause of death (Item :		Daltimaria	D 21221			
J		Donna M. Vincenti, MD Assistant Medical Exam		, ⊳aitimore, M	D 21201			
St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signatur						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				State of Maryland / Department of Health and N	•		33655
				1 - State Certificate of Death		g. No.	33030
		Physici	an.	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Yeer	3. Time of Death
	1	/Medic		Roger Garrettson Kincaid  4a Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	October	25, 2010 4c. County of Death	6:30 P M
•	4	Examin	er	4a. Facility Name (If not institution, give street and number)  Harford Memorial Hospital  Havre de Grace	•	Harford	
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,		place (State or Foreign intry)
		Director		220–18–6456 86 Yrs.	Aug. 6,	1924 Mar	yĺand
		land		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location			10d. Inside City Limits
		Mary Fireho	tor	Maryland Harford Churchville			1 ☐ Yes 2 XNo
		ith the Marylar or 28a-f ehow	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cou	intry?
0		72 hours after death with the Maryland natural; or items 23s or 28s-f ehow dical Examination in the rotified at		2903 Whitefield Road 21028	noofy You or No	USA 14. Race - Amer	ican Indian
3		item item	Funeral	11. Marital Status  12. Was Decedent Ever in U.S.     Armed Forces?  1 □ Never Married 2 ☑ Married  12. Was Decedent Ever in U.S.     Armed Forces?  13. Was Decedent of Hispanic Origin? (Simple of the process) (Simple of	o Rican, etc.)	Black, White	
$\infty$	5-0036	eri, or	þ	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☑ No Specify: Year or Dates:		Specify: Wh	ite
1	2-0	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king	6b. Kind of Business/li	ndustry
	121	within ene. then	mp	Elementary/Secondary (0-12) College (1-4or 5+)  Test Engineer		U.S. Gove	rnment
	d 2	Hygin other ent, II	Be Co		ne (First, Middle, M		
0	ılan	Vental	To B	Charles Herman Kincaid Louisa	Wilkerso	n Jourdan	
1	lar	2 sho	ľ	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru			ip Code)
10/25/10	Baltimore, Maryland 2121	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Manial Hygiens. Department of Health and Manial Hygiens, important: if item 27 is marked other then "natural", or items 23a or 28a-f ehow important: if item 27 is marked other then "natural", or items 23a or 28a-f ehow any Injury or other traumatic event, its Maclical Examination in a content of the property of the proper		C. Michael Kincaid / Son 560 Calvert Road, Ri.  20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place)		MD 21911 0c. Location - City or T	Town, State
7	nor	ages int of it t: If ite y or o		I Digital 2 Escremation 3 Desmoval from State		arcon	
1	altin	nit. Postme cortan injur.		4 Donation 5 Other (Specify) Hilltop Service Corp. 10- 21. Sign ture of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral 1		Towson, Ma	Tytanu
	ä	Depa Impo eny li		50 W. Broadway, I	Bel Air,	MD 21014	
				23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arre	st,	Approximate Interval Between Onset and Death
	7	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Sep 5 / 5'		-	
		Examiner		Due to (or as a consequence of):			
			Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
		acuted and transi	Examiner	that initiated events C.			
0	760,	te be executed ysician and e burial-transit		Due to (or as a consequence of):		1	
a.	687	certificate Iding phys	edic	d.			
20	Box	h cert ending	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of deli	
X		e death the etter	sicie	In the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Month	Day Year
	P.	requires that the een signed by th nould be detache		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
1	ds,	uires n sign	d by		1 🗆 Yes	s 2□No 3□Pro	obably 4 Unknown
0	S O	aw rec is bee	Completed		24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
0	I Re	The law ete has t page 2 s	E O		perform	ed? death?	
	/ita	cisn: ertific ector.	8	examiner?	ath (Check only one	)	
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	ion	nding tth. :: Afte	ation	27. Manner of Death  28a. Date of Injury (Month, Day Year)  28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No		,,	
	Division of Vital Records,	To the Hospital or Attanding Physicism: The law requires that the death certificate within 24 hours effer death.  To the Funeral Director. Affer this certificete has been signed by the ettending phys completely filled in by the funeral director, page 2 should be detached for use as the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str. City or Town,	eet and Number or Ru State)	ral Route Number,
		oital o					
		Hosp 24 ho Fun etely f	Medical	29a. Certifier (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)	e, and due to the ca urred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
سر ا		To the within To the comple	Me	29b. Signature and title of certifier 29c. License number		d. Date signed (Monti	n, Day, Year)
		. •		Muhaward Jobbstan De 060768		Oct. 26, 2	2010
n.	41			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  MUHAMMAD 50 KHADAR 500 VPFER CHESAPEAKE	Dr. Bol	Air, Mr	21014
10		Sta	ate		,	, , , , , , , , ,	
		Registi		31. Date filed (Month, Day, Year)  32. Registrate Signature			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ OCTOBER. 2010 08:50 PM ETHEL KOTZIN Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PIKESVILLE BALTIMORE NORTH OAKS HEALTH CENTER Birthplace (State or Foreign Country)
 MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days Hours Min. 1 M 2 X F 127257 1910 Director 99 Yrs. 214-46-1775 Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho 72 hours after death with the Maryland Director 1 Yes 2 X No BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21208 USA 725 MT. WILSON LANE, #726 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 X Widowed 4 ☐ Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ SOLOMON WHITEHEAD PEARL FREEDMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. EILEEN PEREMEL / DAUGHTER GRISTMILL COURT, #110, PIKESVILLE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) KNESSETH ISRAEL CONG. 10/25/2010 ANNAPOLIS, MD 22. Name and Address of Facility SOL LEVINSON & BROS. . INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Atherosderatic Priysician/ Cardiovasanlar disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 nknown . Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASSITE OR LIVIA 2 ZNO ပ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred injury 1. Natural 5 Pending after death. 2 Accident Investigation within 24 hours after dear To the Funeral Director completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Planmerd Mille-10/24/10 147683 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Ruy

Mond

Miller

2835

J DHMH 17 Rev 7/2009

Smith Avenue Sinte 203

32. Registrar's Signature

Baltmare

21209

MA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle Year **Physician** 2010 /Medical 4c. County of Death Town, or Location of Death 4b\_City Examiner 4a. Fa Memoria Birthplace (State or Foreign County), (In yrs last birthday) Yrs. 8. Date of Birth (Month, Day, Days **Funeral** Hours Director 10d. Inside City Limits the Meryland 10c. City, Town or Location 10b. County 10a State Itsm 27 is marked other than "natural", or itsms 23s or 28s-1 show other traumatic event, the Madical Examinar must be notified at 1 Yes 2 □ No timore Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number deeth with 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Marital Status permit. Peges 1 and 2 should be filled within 72 hours effer c Department of Heelith and Mentel Hygiene. Important: if itsm 27 is marked other than "natural", or itsm any injury or other traumatic event, the Medical Exemplements. Yes 2 □ No Wes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes → No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Nettles William sernice 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ·43ed Street, Bato MU 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition ଚ Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) INGSMILS Funeral Service 21. Signature Funeral Service Lice Julto MD 21212 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) · Acute sundrome COLOWORA Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ettending physicien end for use as the burlal-transit The lew requires that the deeth certificate be executed Division of Vital Records, P.O. Box 68760,子 Due to (or as a consequence of): Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown After this cartificete has been signed by the e funerel director, page 2 should be deteched 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 1 ☐ Yes 2 XNo 3 Probably 4 Unknown Heart Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an pertension autopsy performa 1 Tyes 2 No To the Hospital or Attending Physicien: within 24 hours after deeth.

To the Funeral Director: After this cartiflor complately filled in by the funeral director, i 25. Was case referred to medical 26. Place of Death (Check only one) 8 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient ို 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Memorial Bruce Waxson 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 50 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Age (Inlyrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Funeral rs. **3** Min. **Director** 28a-f shov death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** the Medical Examiner must be notified 1 Yes 2 No more P 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 □ Divorced "natural" Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiens Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) nday (6-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/23 7 20b. Place of Disposition (Name of cemetery, crematory or other Method of Disposition Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) 21. Signature of Funeral er ice Licensee no 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition resulting in death) # Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Year 1 Yes 2 L 9 Unknown Division of Vital Records, P.O. been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an nas e 2 autopsy s certificate has director, page 2 perforn 2 N 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury 5 Pending 1 Yes 2 🗌 No neral Director: A 2 Accident Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completed filled i 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of

KK AY C

21239

(Item 23a) (Type, Print)

5601

32. Registrar's Signature

erson who completed cause of death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ LEWIS 6:55 PM DENNIS 2010 October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL 3altimore HARBOR N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, Min Months Hours Mary land 216-42-9053 Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Medical Examiner must be notified at Director N/A Maryland Curtis Bay 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 4200 Pennington Avenue items 23a 21226 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Armed Forces? ò 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ns
any injury or other traumatic event, the Medic (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) K & W Finishing Bookbinder 11Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ A. McChellan William Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph A. Lewis (Son) 2039 Kurtz Avenue, Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State netery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Atlantic Crematory 10-22-10 Glen Burnie, Marylan D 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility McCully-Polyniak Funeral Home P. A <u>3204 Mountain Road, Pasadena, Maryland 21122</u> 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) Severe Encephalopath Medical Due to (or as a consequence of). Examiner Known HEAV Y alcoho Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy this certificate 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 🗷 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital Other: 2 X No 1 Na Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred injury 1 Matural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

DHMH 17 Rev 7/2009

Resident - PGY-I

Woldesenbet

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Abera B. 31. Date filed (Month, Day, Year)

32. Registrar's Signature

29c. License number

3001

-00

Baltimore

Hanover

MD

29d. Date signed (Month, Day, Year)

2010

October

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible.

			For Amend Item 25 State Registrar	State of Man	/land/27 8,10/27 C	<b>72010dhb</b> F ertificate of D	lealth and N Death		iene 201	0 33660		
	Physicia	n/	1. Decedent's Name (First, Middle, Last,					Date of Deat     Month	h Day Year	3. Time of Death		
	Medic		Evelyn S. Mathis						17 2010	7:24 A M		
``	Examin	er	4a. Facility Name (if not institution, give s Southern Maryland			4b. City, Town, or Clinton	Location of Death		4c. County of Dea			
	Funeral	Š	5. Social Security Number 6. Sex		yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	g, Bir	thplace (State or Foreign		
	Director		241-02-0133	M 2 🔀 F	69 Yrs	Months Days	Hours Min.	Nov. 3,	1940 Nor	th Carolina		
	ind show at	or	Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or	Location				10d. Inside City Limits		
	Maryla 18a-f tified	Funeral Director	MD Prince Ge	orge's	Suitlan	d				1X Yes 2 ☐ No		
	the last	Ö	10e. Street and Number			10f, Zip Code		1	10g. Citizen of What Co	ountry?		
	h with	nera	1805 Porter Avenue	<u> </u>		20746			USA			
21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status  1 Never Married 2 XXMarried  3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	in U.S.	<ol> <li>Was Decedent of Hi If Yes, specify Cuba</li> <li>1 ☐ Yes 2 X No</li> </ol>	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: B1a	e, etc.		
2-0	2 hour "natu	plet	15. Decedent's Edi (Specify only highest grad		i (Gi	cedent's Usual Occupa	ation during most of worki	ing	16b. Kind of Business	Industry		
121	ithin 7, ene. r than the Me	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+) years	life	.DONOT use retired) cher's Aid	_		DC Public	Schoole		
פַ	illed wall Hygi	Be B	17. Father's Name (First, Middle, Last)	, yours	e (First, Middle, N		Belloois					
ylar	ld be Menta arkec atic e	입	Fred Lee Smith				Normanda	Rouse				
Nar	shou h and 7 is m traum		19a. Informant's Name/Relationship (Typ			•			City or Town, State, Zi	p Code)		
ē,	Heall tem 2		Robert P. Mathis, 20a. Method of Disposition		20b. Place of Dis	5 Porter Argonisis Porter Argonistion (Name of			MD 20746 20c, Location - City or	Town, State		
<u>m</u>	Page 1 nent of 8 ant; If its		1 XBurial 2 ☐ Cremation 3 ☐ I			rematory or other plac Memorial	10/22		Suitland, N			
Baltimore, Maryland	permit. Page Department Important: I any injury or		21. Signature of Funeral Service License	Lowih					arch Funera d, MD 20746			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between									
- 1	Physician	8 8	Immediate Cause (Final disease or condition resulting in death)	Acuk		monan	4 Em	ball	S	Onset and Death		
-	Medical Examiner		resulting in death)	Due to (or as a co	nsequence of):	021 9110	J CONLC	pront	77.1			
		iner	Cequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co	nsequence of):	17 001	9//					
	cuted and transit	Examiner	Cause (Disease or ilinjury that initiated events	Due to (or as a co	1005	shuche	2	SVAMINER .				
	icate be executed physician and s the burial-transit	calE	resulting in death) Last	Due to (or as a co	nsequence oi).		V.	APPROVED BY ME	DICAL EXAMINER			
220	icate g phys	ledical		1			CERTIFICATION	V.				
Division of Vital Records, P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months?	3c. If yes, outcome of p 1 Live Birth 2 4 Pregnant at tim 9 Unknown	Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify)			23d. Date of de Month	elivery Day Year		
o O	at the o		9 Unknown  Part II. Other significant conditions con		ot resulting in th	e underlying cause giv	ven in Part I.	23e Did tob	id tobacco use contribute to the cause of death?			
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200	The law re cate has be page 2 sho	Completed						24a. Was ar autops perfor	y prior to	utopsy findings available completion of cause of		
ž	n: The ficate or, pag		25. Was case referred to medical			26 日	ace of Death (Check	1 L Yes	No 1 □ Ye	s 201 No		
Vita	/sicia s certi	To Be	eyaminer?	ospital:	≥√ ER/Outpa	Othe	ar.		ence 6 🗆 Other (Spec	nify)		
n of	nding Physician: T th. : After this certifics s funeral director, p		27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Ye.	28b. Time	e of 28c. Injury Work	/ at		w injury occurred			
ivisio	Il or Attend after death Director: A d in by the f	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (Sp		street, factory, office		28f. Location (St. City or Town	reet and Number or Ru , State)	ıral Route Number,		
	e Hospita 124 hours e Funeral leted fille	Medical	(Check 2 Medical Examin	cian: To the best of my ler: On the basis of exami	ination and/or inv	estigation, in my opinic	on, death occurred at	the time, date an	d place, and due to the	cause(s) and manner stated.		
	To th withir To the	2	29b. Signature and title of certifier		,	29c. License			9d. Date signed (Mont	h, Day, Year)		
				K, MD	)	D0062	057		10/17/2	2010		
			30. Name and address of person who co Sandra Banks, MD 7	mpleted cause of death 503 Surrat	(Item 23a) (Type s Road	e, Print) Clinton, M	D 20735					
State 31. Date filed (Month, Day, Year)  Registrar  OCT 2 7 2010  32. Registrar's Signature												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10-19-2010 Anthony Miller, Sr. 2:57 Αм Joseph Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Care Towson Social Security Number 9. Birthplace (State or Foreign Country) MD If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Days Hours Min 1 🔀 M 2 🗆 F **Director** 217-40-2924 67 Yrs. Usual Residence of Decedent or 28a-f shov 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director must be notified 1 🗆 Yes 2 ื No MD Rosedale Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a Examiner must be Funeral United States 5211 Daybrook Circle, Apt. 21237 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Be Completed by 1 Never Married 2 Married 2 🛚 No 1 Yes : Maryland 21215-0036 1 Yes 2 No Specify: 3 XXWidowed 4 □ Divorced Year or Dates White or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Clerk-checker Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even ျှ Miller Marie Steiger Raymond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan R. Miller - Daughter 5211 Daybrook Circle, Apt 331, Rosedale, MD 21237 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem Park |10-23-2010 |Elkridge, Maryland 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signature of Funeral Service Lie MMP, Inc.,7250 Wash Blvd, Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of such line. Approximate Interval Between Immediate Cause (Final Onset and Death Non Pnysician/ CCL unters disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, it is a factory to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Physician/Medical Examiner To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Year Pregnant at time of death Yes 2 No Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes 2 No Yes 25. Was case referred to medical å 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 읻 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

30. Name and add

ss of person who completed cause of death (Item 23a) (Type, Print)

Standard Market Ma

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. C Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ MINTER 0537 M Hnnie 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Regional t Hoski aurel Laurel Prion ce H300 V 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** 1 M 2 KF Days Hours Months 1270171920 89 Director 252-34-7766 Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Completed by Funeral Director items 23a or 28a-f 1 X Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20017 5009 13th St NW USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 🙀 Never Married 2 🗌 Married ò 2 XNo ☐ Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: Black "natural", 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. I other than " Office of Personnel Elementary/Seconday (0-12) College (1-4 or 5+) <u>Voucher Examiner</u> Management permit. Page 1 and 2 should be filed Department of Health and Mental Hy, Important: If item 27 is marked othe any injury or other traumatic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ada Thomas Sherman Minter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7816 Hanover Parkway Greenbelt, MD 20770 Apt 203 Paula Ball/neice 20b. Place of Disposition (Name of 20a, Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Brentwood, MD Lincoln cemetery 10/26/2010 Donation 5 Other (Specify) 22. Name and Address of Facility Marshall-March Cemetery 21. Signature of Funeral Service Licen Janes 4217 9th\_St\_NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a d **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months' Month Day Year 5 Other (specify) Pregnant at time of death 1 Yes 2 4 9 Unknown Yes 2 No Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? within 24 hours after death.

To the Funeral Director: After this certificate has been signed I completed filled in by the funeral director, page 2 should be det Certificate: To Be Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? rmed 2 2 No 1 Yes Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manney f Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred iniurv 5 Pending Natural Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29c. License numbe

State Registrar

31. Date filed (Month, Day, Year)

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rson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

**Timothy Curtis Nevels** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day October 15, 2010 1127 hrs **Medical Examiner** Timothy Curtis Nevels 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Montgomery I-95 Between 216 & Route 32 Scaggsville 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Days Hours Months Director 450-43-2938 Country) 1 X M 2 Yrs 2-1965 45 Usual Residence of Deceden 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits unk No 2 No s 23a or 28a-f show e notified at once. 28a-f show MD imore, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
Instit. If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country USA Funeral 14, Race - American Indian, Black, 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 1 Yes specify African-American 3 Widowed 4 X Divorced If Yes, Give Year Yes 2 X No specify: \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 2 FFE Trucking Trucking 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Bertha Bradley Benjamin Nevels 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9060 Allenswood Road, Randallstown, MD 21133 Yvette Harcum/ Ex-Wife 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Itimore, crematory or other place) 1 Burial 2 Y Cremation 3 Removal from State 10/29/2010 Department o Baltimore, MD Metro Crematory 4 Donation 5 Other Specify: While Funeral Home P.A. of Balto. Co. 22. Name and Address of Facility 21. Sunature of Funeral Service License ON 9200 Liberty Road, Randallstown, MD 21133 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line /Medical Death a Pulmonary Thromboembolism Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) b. Right lower extremity deep vein thrombosis Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last ned by the attending physician and detached for use as the burial - transi The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown P.0 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. certificate has been signed by rector, page 2 should be detach ⋧ 1 Yes 2 No 3 Probably 4 Unknown Completed Records, 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed death? ✓ Yes 2 No 1 🗸 Yes 2 No Fo the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital æ Hospital: 1 Inpatient 2 Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA this 1 V Yes 2 No After 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 1 V Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: the Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. October 16, 2010 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. 31. Date filed (Month, Day, Year . Registrar's Sig State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene dr., g908, 10/28/2010 Mental Hygiene Certificate of Death Reg. No. Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup>30 Physician/ uen ( 2010 September 2:29 AMM Medical 4a. Facility Name (if not actitution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Glen Burnie Anne Arundel Medical Center Annapolis 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 □ M 2 💢 F Hours Min Mary Tand 83 Director 212-26-7452 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No MD Anne Arundel Annapolis 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 805 Coxswain Way #103 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc ģ 1 Never Married 2 Married white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify. 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) financial accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Helen Louise Dawson Leroy Emil Meyette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Gode) 805 Coxswain Way #103 Annapolis, MD 21401 Richard Owens Jr/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Signuture of Euneral 340 Stare Androny Board 655 W. Baltimore Street rector Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. 20 y Immediate Cause (Final Coronary Artery Disease Physician/ disease or condition resulting in death) Medical to (or as a consequence of): Hyperlipidemia SPOLP Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine de of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director, After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burlansit s been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (o) as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Year Day Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Yes 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 1 Tes Be ( 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: မ 1 Tyes 2 1 Inpatient 2 R/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Nonth, Day, 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes Investigation ☐ Suicide ☐ Homicide 6 Could not be lace of Jury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Signature and title of certif 29b. 29c. License number

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) October 7,2010 **Physician** 6:48pM ADELINE "/Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Baltimore n/a Caton Manor 8. Date of Birth (Month, Day, Year) 08/16/1920 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Numbe **Funeral** Months Days Hours 1 M 2 T 89 Director 577-26-8891 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" --- any injury or other traumatte everance. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 □ No Baltimore n/a Md10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21217 702 North Carrollton Avenue USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify ð BLACK 3 ☐Widowed 4 ☐ Divorced Year or Dates Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carnation Milk Sales & Promotion 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha Baynum Brown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3510 Wilkens Ave Baltimore, MD 21229 Francis Pullen Jr.-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10.14.2010 | Arbutus, MD Arbutus Mem Park 21. Signature of Juneral Service License Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, MD 21215 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Part1 Inter the dise show, or heart failur Immuniate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-trans attending physician and resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 1 ☐ Yes nknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No this certificate Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident death the Director; 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined filled in by 4 Homicide within 24 hours a To the Funeral C To the Hospital tticertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who comp

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** The Johns Hopkins Hospital Baltimore City If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Social Security Number . Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 **X** F Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 ☐ No Director 10e. Street and Number 10g. Citizen of What Country? by Funeral Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working fife. DO NOT use retired) Elementary Secondary (0-12) College (1-4 or 5+) Be Pages 1 and 2 should be innent of Health and Mental is ပ္ permit. Pages 1 and Department of Healt Important: If item 2 any injury or other: 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signatur of Funeral Se vice Li ensee M0155 pproximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arres shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician pirator /Medical consequence of) **Examiner** Sequentially list conditions, if any, loading to in modilate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit requires that the death certificate be executed Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ of Vital Records, 2 No 3 Probably 4 Unknown 1 Tes Completed To the Hospital or Attending Physician: The law requivithin 24 hours after death.

To the Funeral Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy perform 2 No 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 
Nursing Home 2 No 1 Dinpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) မ 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: Division (Month, Day Year) Injury 5 Pending investigation Μ 1 Yes 2 🗌 No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

DHMH 17 Rev 1/2001

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#5perFH G909 11/30/2010 WS State of Maryland 7 Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October ( Elsie R Pusloskie T9.2010 6:32A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Dove House Westminster Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 XX Days April 27 West Virginia 81 Yrs. 1929 Director Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Arbutus 1 🗆 Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1712 Hall Avenue 21227 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 XWidowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname)
Katie Whittington 17. Father's Name (First, Middle, Last) George Carper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3455 Shiloh Road Hampstead, MD 21074 Gail Sheetz (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial Park Elkridge, MD 4 Donation 5 Other (Specify) Name and Address of Facility Bry L. Kaufman 250 Washington Funeral Blvd., Home at MMP, Inc. Elkridge, MD, 21075 23a. Part 1. Enter the disease, or complications that cau shock, or hear failure. List only one cause on each e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical s a consequence of Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the bunial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Pregnant at time of death 5 Other (specify) Day signed by the all Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed certificate has been si lirector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 🗆 No Yes 2 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ည 1 Yes Dove 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specific 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred House 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) completed cause of death (Item 23a) (Type, Print) Calm drive Westminim MW 2/1577

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 33668 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician/ Month 1.50 2010 tober Medical ROWSHIM 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days Hours Mir 1 M 2 F Months 212-14-4409 86 Yrs. Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hyglene. is marked other than "natural", or items 23a or 28a-f shon or 28a-f shov 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at Director 1 Tes 2 No Windsor Mill Baltimore MD 10f. Zip Code 21244 10g. Citizen of What Country? 10e. Street and Number Funeral 7101 Hull Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14, Race - American Indian, 11. Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: African-American 3 ₹ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Hot Shop In Flight Caterer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Pearl Mears Henry Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau once. Gileer L. Downing/Daughter 7101 Hull Ct., Windsor Mill, MD 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Garrison Forest Veterans 11-8-2010 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wile Functal Home P.A. of Parto. Co. Sign inve of Funeral Service Licensee 9200 Liberty Road, Randallstown, MD 21133 23a. Part). Enter the disease, or complications that caused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death -Pnysician/ disease or condition resulting in death) Pul Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and the for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ 1 Live Birth 4 Pregnant 9 Unknown in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 2 should be detached g Unknown signed by Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page performed Yes 2 No Yes 2 No the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 욘 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) after death. Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 Natural work? 1 🗌 Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined within 24 hours a To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 02908

DHMH 17 Rev 7/2009

State Registrar 5401

32. Regist ar's Sign ture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010 Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33669 = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 6.25AM Rita Annette Richburg 20 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/ABaltimore Good Samaritan Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Hours (Month, Day, Year) 217-40-5557 Director 67 MD Usual Residence of Decedent or items 23a or 28a-f show miner must be notified at 10b. County 10a. State Director 10c. City. Town or Location 10d. Inside City Limits N/A MD Baltimore 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3205 Elmley Avenue 21213 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🌠 No If Yes, Give "natural", edical Exar 1 Yes 2XXNo Specify: Specify: Completed 3 Widowed 4 Divorced Black Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Lab Techniciañ Rockland Industries 12th Grade permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, th Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Elmer Leroy Banks Annette Peyton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Natalie L. Richburg/Daughter 6214 Radecke Ave. Baltimore, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 N Other (Specify) Entombment Woodlawn Cemetery Woodlawn, Maryland . Signature of Funeral Ser 22. Name and Address of Facility Chatman-Harris Funeral Home 4210 Belair Road Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician. disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner GULOP Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner ROMB signed by the attending physician and deed betached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) Unknown 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? VULGARIS, 2 No 3 Probably 4 Unknown 1 Tes peen ULCERS, ACUTE 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed After this certificate has page 2 1 Yes 2 No 25. Was case referred to medical examiner? filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DCA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No hours after death Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined -124 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) within To the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOCH RAVEN BLUD, BALTIMORE, MD-21239 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

27

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 per me,g909, 11/19/2010dhb ar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 6:25PM 2010 Medical Junious Rodgers 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Memorial <u>Hospital</u> Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1**X** M 2 □ F Hours Min. **Director** 85 Yrs 50-28-1039 Usual Residence of Deceden or 28a-f shov 10a. State r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21218 U.S.A. <u>926 Northill Road</u> Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: Black 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) MD Nat'l Bank Chauffeur 6th grade na Be or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Abraham Rodgers Margaret Barr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Louis 20a. Method of Disposition Northill Road, Baltimore, Md 21217 Louise Rodgers-Wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) cemetery, crematory or other place) injury ( Memorial Park <u>10/28/2010 Woodlawn, Md</u> of Funeral Service License Sina 22. Name and Address of Facility March F/H West 4300 Wabash Av Baltimore. 21215 23a. Palt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ / Medical bleeding disease or condition resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of) PANNELL OF THE MEDICAL EXAM To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After the death certificate be executed. nding physician and use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month cate has been signed by the a page 2 should be detached to 9 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 🗆 Yes 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 XInpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Natural 2 Accider 5 Pending (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No М Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO AT2438946 10/22/2010

Registrar

DHMH 17 Rev 7/2009

State

E University PKWY

Baltimore MD 21218

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Medical Examin	er	Ronald S	cott	Su	llivan							,	Month October 7	7, <b>20</b> 1			1949 hrs	
E		4a. Facility Name (if no 9804 Emerald		give	street and nur	mber)		ľ	4b. City, <b>New</b>	Town, or Le	ocation of	Death			c. County of Charles	Death		
Funeral	4	5. Social Security Num		S. Sex	Т	7. Age (Ir	n yrs. last l	birthday)		der 1 Year	If Under	24Hrs.					nplace (State or Foreign	
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Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shu injury or other traumatic event, the Medical Examiner must be notified at once.	1	1 Burial 2 X	Cremation		Removal fro	om State	crer	natory or oth	ner place	9)				1				
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BO)	2	1 Yes 2 No			9 Unkno								Tan ali	丄				
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Division of Vital Records, P.O. Box 6876 To the Hospital nr Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician physician in the funeral director, page 2 should be detached for use as the intermediate of the completely filled in by the funeral director, page 2 should be detached for use as the intermediate of the completely filled.	<u>ea</u>	(Officer of ity			n: To the bes	-	_											
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Registr	ar	31. Della Korn.	2010"	1	enema	A		Med										

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #7 Per FH G908 10/27/10 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death OCTOBER 21 **Physician** 2010 STRZEGOWSKI JUDITH D. 8:20a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 7028 BANK STREET HIGHLANDTOWN If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 10/16/1950 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🔀 F MARYLAND 60 80 Director 212 56 3169 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No MD BALTIMORE HIGHLANDTOWN Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7028 BANK STREET 21224 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or ite 1 Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2 No 3altimore, Maryland 21215-0036 Specify Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) HAIRDRESSER HAIRDRESSER 12 traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ZIPPLER BERNARD ADAMS ANNA MARIE ဂ္ 19a. Informant's Name/Relationship (Type. Print) HUSBAND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traun once. ALBERT L. STRZEGOWSKI 7028 BANK STREET BALTIMORE, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State SACRED HEART JESUS 10/25/10 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTIMORE, 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final astation breast Juc-Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a 9 Unknown 9 Unknown signed by t t be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ò 2 No cate has been sig , page 2 should b 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy 1 Yes 2 □ or Attending Physician: 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manper of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1. Natural Injury 1 ☐ Yes 2 🗌 No nours after death.

neral Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a: To the Funera! D Hospital 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific

State Registrar DHMH 17 Rev 1/2001

gistrar OCT 2 7 2010



PESSI #210 Bautimor, Md. 2120

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 10 Certificate of Death 3. Time of Death 9:15 A M 1. Decedent's Name (First, Middle, Last) 2. Date of Death OCTODES **Physician** 2010 Marry Ann Sands /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner AGNES HOSAITHL BALTIMORE  $m \Delta$ n/a If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 □ M 2X F 7-3-1940 213-38-9643 Director Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Even, that the matthed at 1 ☐ Yes 2 No Baltimore Gwnn Oak Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21207 USA 1121 St. Agnes Lane Apt. 117 Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No African-American Specify: 2 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 9th All Saints Convent Cook 18. Mother's Name (First, Middle, Maiden Surname) anould be final than and Mental Hv 17. Father's Name (First, Middle, Last) Be Viola Marie Brown Robert Frederick Cole 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau 11 Adil Court, Catonsville, MD 21228 Carolyn Leigh/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-29-2010 West Liberty United Meth. Marriottsville, MD 22. Name and Address of Facility Wylie Funeral Home P.A. of Baito. Co. 21. Signature of Funeral Service License 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Probable hours **Physician** myocardia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner were coronary as Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit hypertension
Due to (dr as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 ☐ Other (specify) the a cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 ☐ No 24a. Was an autopsy performed After this certificate Division of Vital Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1. Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 □ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 141843 October 25 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 STONAVE BALTIMORE, MOZIZZG REED 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

**O**RIGINAL

10-08106 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Zachary Ryan Taylor Smith 1- For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day October 23, 2010 Medical Examiner 0947 hrs Zachary Ryan Taylor Smith 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Agnes Hospital 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Hours Director 5-17-1991 214-41-6916 19 LA 14 M 2 F Country) Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No s 23a or 28a-f show e notified at once. Baltimore Pikesville Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must he notified as annualing any or other traumatic event, the Medical Examiner must he notified as annual and the model of the second of 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ā 2916 Old Court Road IISA 21208 Funeral 11 Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian, Black, Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes 3 Widowed 4 Divorced f Yes. Give Year Yes 2 X No specify: Specify: African-American δ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Good News Electric Electrician 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Zed A.Smith Rhonda Owen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2916 Old Court Road, Pikesville, MD 21208 Zed A. Smith/Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Entambrent crematory or other place) 1 Burial 2 Cremation 3 Removal from State 10-30-2010 Pikesville, MD Druid Ridge Cemetery 4 Donation 5 Other Specify: While Funeral Home P.A. of Palto. Co. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 9200 Liberty Road, Randallstown, MD 21133 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Between Onset and (Medical Death Methadone intoxication and cocaine use Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit cian/Medical UNPENDED AMENDED 23a,27,28a-f, per ME g910 12/7/10 TT attending physician a Box 68760, 23d. Date of delivery IF FEMALE 23c. If ves. outcome of pregnancy 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown the certificate has been signed by the ector, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? P.0. ≦ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed Division of Vital Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? ✓ Yes 2 No 1 🗸 Yes 2 No t Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: this 1 Yes 2 No 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending Fd 10/23/10 Fd 9:05 am Funeral Director: 2 Accident Investigation 28f. Location (Street, and Number or Rural Route Number, City or Town, State)+01/ Frederick Ave 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide house determined (Specify) Homicide Baltimore, 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number October 24, 2010 O.C.M.E. rele 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

			<b>1 –</b> For State Registrar	State of Mar		rtificate of			g. No.2 0   0	33675			
	Physici	an	1. Decedent's Name (First, Middle, Las HELDI S	TECK				2. Date of Death Month	Day Year	3. Time of Death 5 45 PM			
-	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death		21 2010 4c. County of Deat				
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	Funeral Director		213 30 000.	ex 7. Age ( □ M 2 F	In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 10 – 21 –	Yea <i>r)</i> 9. Bird Co	thplace (State or Foreign ountry) STONIA			
	land ow f		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town or Lo	cation				10d. Inside City Limits			
	Mary a-f she	tor	MD BAL	TIMORE		RO	SEDALE			1 ∐ Yes 2 🛣 No			
	th with the 23a or 28	Funeral Director	10e. Street and Number 907 CHESACO A	VENUE		10f. Zip Code	21237	10	g. Citizen of What Co	,			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat roust be notified at once.	b	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1  Yes  No If Yes, Give Year or Dates:	lf Yes, specify Cuban, Mexican, Pi			pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify: W				
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br	al Hyg other vent,	BeC	17. Father's Name (First, Middle, Last)	st, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)									
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	alth an alth an 27 is r			mant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,  11725 FRANKLINVILLE RD BALTIMORI									
Baltimore,	Pages 1 and of the out; If item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif.		20b. Place of Dispo cemetery, crem				0c. Location - City or BALTIMOR				
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DHMH 17 Rev 1/2001

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		-	For State Registrar		ertificate of Death	Reg. 1	21111 3367b
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<b>21215-0036</b> within 72 hours after	e. Ian "natu Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Seconds (0-12)	completed)   (Giv	edent's Usual Occupation re kind of work done during most of we DO NOT use retired)	orking 16b	Kind of Business Industry
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Baltimore, permit. Page 1 and	t of Fil		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	position (Name of ematory profite place) 11-	3-2010	Location - City or Town, State  Dwings Millys, MD  COCHSVIIIE MD
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Box 68760 death certificate be	attending physician and for use as the burial-transit	by Physician/Medica	in the past 12 months?	5. If yes, outcome of pregnancy 1  Live Birth 2  Fetal death 3 4  Pregnant at time of death 5	Ectopic pregnancy		23d. Date of delivery Month Day Year
P.O. Bo that the de	g 9	Physi	1  Yes 2 No 9 Unknown  Part II. Other significant conditions confr	g 🗌 Unknown		23e Did tobacc	co use contribute to the cause of death?
<b>IS, P.</b> uires the	been signed by the should be detached	ed by	— Still Significant conditions condi	Editing to doubt but not rooming in an			2 □ No 3 □ Probably 4 ☑ Unknown
Division of Vital Records, alor Attending Physician: The law requires	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach	Completed				24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?  No 1  Yes 2  No
tal R ian:	ertificate ctor, pa	Be Co	25. Was case referred to medical examiner?	- Mali	26. Place of Death (CI	1 Yes 2	
of <b>Vi</b>	erthis or	₽	27. Manner of Death	28a. Date of injury 28b. Time	oi 28c. Injury at	Home 5 Residence	6 Other (Specify)
ion ( tending	leath. Ior: Afte the fune	Certificate:	1 Matural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Year) injury	M 1 ☐ Yes 2 ☐ No	DOLL	Annal Mirrobara y Prival Parita Mirrobar
Divis tal or At	rs after or al Direct led in by		4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)		City or Town, St	
e Hospi	n 24 hou ie Funer	Medical	(Check 2 Medical Examine)	an: To the best of my knowledge, deat : On the basis of examination and/or inv Practioner: To the best of my knowledge	estigation, in my opinion, death occurre	d at the time, date and pl	ace, and due to the cause(s) and manner stated.
라 라	To tt		29b. Signature and title of certifier ASRy apartle	MID	29c. License number DOUS 7 46		Date signed (Month, Day, Year)
	6				sminh S. 203	5- Baltimo	re, MO 21209.
	Sta	te	30. Name and address of person who com  N · S · Ray · P · N  31. Date filed (Month, Day, Year)	32 Registrar's Signature	barker		

			For State	State of Maryla			nt of H		and M			201	n	336	77
			Registrar  1. Decedent's Name (First, Middle, La.	st)		rtmea	ie or L	Catri	— т	2. Date of Dea	Reg. No.	<u>_ 0 1</u>	$\frac{\circ}{}$	3. Time of Dea	1 1
	Physicia Medic	al	Melvin F.  4a. Facility Name (if not institution, give	Seward, Jr		141 071	4b. City, Town, or Location of Death				r 20	. 2010		10:20	
	Examin	er	8024 Tower Bridge						r Death		1	4c. County of Death Anne Arundel			
	Funeral		Social Security Number 6. S	x 7. Age (In vrs. last birthday) If Under 1 Year If Und					24 Hrs.	8. Date of Birt	th			ice (State or Fo	reign
	Director		219-32-6147	X M 2 □ F 73	Yrs.	Months	0ays	Hours	Min.	March Day	26.19	00-	Country		
	- M		Usual Residence of Decedent			<u> </u>	-								
	yland f she	cto	10a. State 10b. County	10c. 0	City, Town or Lo	cation							100	d. Inside City Li	
	Mar 28a- notifi	Jire	Maryland Anne A	rundel Pa	sadena									_	<b>∆</b> No
	th the	le.	10e. Street and Number	_			ip Code			i	10g. Citi:	zen of What		y?	
	ms 2 mus	Funeral Director	8024 Tower Bridge	Drive 12. Was Decedent Ever in I	110 140	_	1122	anania Oria	in? (Cnoo	ify Yes or No-		U.S.		In the	
(0	or ite	by Fi	1 Never Married 2 X Married	Armed Forces?	0.3.	If Yes, sp	ecify Cuba	n, Mexican,	, Puerto R	Rican, etc.)		14. Race - Ar Black, Wi			
036	s after		3 Widowed 4 Divorced	If Yes, Give Year or Dates.		1 🗌 Yes	2 🔀 No	Specify:			5	Specify: W	hit	<b>e</b>	
215-0036	within 72 hours after death with the Maryland glene. than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner.	Completed	15. Decedent's E (Specify only highest gr		16a. Dece			ation luring most	of workin		16b. Kir	nd of Busines			
7	nin 72 ne. han '	E O	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. D	O NOT u	se retired)		OF WORKIT	g					
12	d with hygier ther t	(a)	11 17. Father's Name (First, Middle, Last)	N/A	F	<u>iref</u>	<u>ighte</u>					ltimor	<u>e C</u> :	ity	
anc	ntal F ed or	10 W 1										,			
Maryland	s should be filed within 72 h and Mental Hygiene. 7 is marked other than " traumatic event, the Mec		19a. Informant's Name/Relationship (		40h Maili		/C4===4 =			Burne				ckles_	
Ma	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene.  Ithem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Delores A. Seward							Route Number					
ē,	1 and 2 soft Health item 27 other tra		20a. Method of Disposition		. Place of Dispo	osition (Na	ame of			e Pasac		cation - City		d_21122 n, State	
90	e it is		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		cemetery, createn Hav	•		· .	0/22	/10	01	D		M 7	,
Baltimore,	# 6 4 5	1	21. Signature of Funeral Service Licen	. 1 9	ten nav	2. Name a	en P and Ad <u>d</u> res	K : 1	<u>U/ Z3</u>	/10 1	Gler	Burn	10	Maryla	na
m	Depar Impo any ir	- 33	John to	follens.	M   3	204	Ly-Po Mount	lynia ain R	k Fu oad	neral H Pasader	Home,	, P.A. Marvla	nd :	21122	
			23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approximate nterval Between	n
- F	h, sician/	'n	Immediate Cause (Final disease or condition	Chileri	o Scher	0712	Car	dol	lasco	May	B 80	Colyc		Onset and Deat	
	Medical Examiner		resulting in death)	a. Dua to (or as a conse	equence of):								T		
	<b>L</b> Xdiiiiici	į.	Sequentially list conditions,	b. Dome	419								-		
	ed Isit	Ē	if any, leading to immediate cause. Enter Underlying Cause (Disease or liniury	Due to (or as a conse	equence of):	M									
	xecut n and al-trar	Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of):										+		
90	The law requires that the death certificate be executed attends been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner		10 Drake	Tes										
9289	eath certificate attending phy for use as the	Med	IF FEMALE:											71 31	_
Ø ×	endir r use	an/l	23b. Was decedent pregnant	23c. If yes, outcome of preg		☐ Ectopic	c pregnanc	v			2	23d. Date of		•	
Вох	death he att ed fo	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of ☐ Unknown		Other (		,				Month	D	ay Year	
P.O.	that the dea led by the a detached f		Part II. Other significant conditions of	ontributing to death but not u	resulting in the I	underlying	a cause div	en in Part I		23e Did to	obacco III	ee contribute	to the	cause of death	2
Ф,	res th signe	Completed by		J		,	, J				Yes 2			bly 4 🗆 Unk	
ğ	v requires the been signer should be a	ete								24a. Was		,		y findings avail	
ecc	e law e has ge 2 s	ш								autop		prior death	to com	pletion of cause	
<u>=</u>	sician: The la certificate ha irector, page 2		25. Was case referred to medical				26 Pla	ace of Deatl	h (Check	1 L Yes	2 No	1	Yes 2	No	
Vita	ysicia iis cert direct	To Be	examiner? 1 Yes 2 No	Hospital:	☐ ER/Outpatie	nt 3 🗆	Othe	)r:		ne 5 X Resid	dence 6	Other (Sc	ecify)		
of Vital Records,	g Physer this neral di		27. Manner of Death	28a. Date of injury (Month, Day, Year)	28b. Time o		28c. Injury work	/ at		8d. Describe h			,001197		
on	ttending I death. stor: After / the funer	fica	1 Natural 5 Pending 2 Accident Investigation	n	,	М		Yes 2 🗆	No						
Division	I or Attend after death Director: /	Certificate:	3 ☐ Suicide 6 ☐ Could not to 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec		reet, facto	ory, office		2	8f. Location (S City or Tow		Number or	Rural R	oute Number,	
Ö	the Hospital or Attending Physician: hin 24 hours after death the Funeral Director; After this certific apleted filled in by the funeral director,		29a. Certifier 1 X Certifying Phy	releign. To the heat of and	audadaa deed	000111-1	at the a t	dot '	alan :	Lakia A. Al		d =====	atete -		
	Hospital 24 hours Funeral I	Medical	(Check 2 L Medical Exam	sician: To the best of my kno iner: On the basis of examina se Practioner: To the best of	tion and/or inves	stigation, i	n my opinio	n, death oc	curred at t	the time, date a	and place,	and due to the	ne caus	e(s) and manner	rstated
	To the I within 2 To the I сопре	2	29b. Signature and lifte of certifier	Se l'actioner. To the best of	my knowledge,		oc. License	_	and place			e signed (Mo			
			1	arn			D/4	7820	C		j	0/=	رر	12010	5
12			30. Name and address of person who	completed cause of death (It	em 23a) (Type, I	Print)			_			- 10	-1/		
10			Christopher	deBoria	345	Sh	Que	tae	- K	d Pa	isad	ena h	nes	. 211-	11
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 7 2010	32. Registrac's Sig	nature										

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 33678 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October ( 2010 2:45 AΜ Mary Alice Taylor Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death n/a FutureCare Lochearn Baltimore Age (In yrs, last birthday, If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Days Months Hours Min. (Month, Pay, Year) C. 14, 1950 South Carolina Director 212-58-0111 59 Dec. Usual Residence of Decedent show Mental Hygiene. narked other than "natural", or items 23a or 28a-f shov natic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 X Yes 2 ☐ No MD n/a Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5014 Goodnow Road Apt. 21206 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status Race - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes : 2 🔀 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City Health Dept. 12th Grade Receptionist Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Unknown Sallie R. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3733 Dolfield Avenue Baltimore, Maryland 21215 Jenine Jackson - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 10/23/2010 Baltimore, Maryland Green Mount Crematory 21. Signature of Funeral Service Lio 22. Name and Address of Facility Chatman Harris Funeral Hore 5240 Reisterstown Road Baltimore, Maryland 21215 ros 23a. Part 1. Enter the disease, or complications that caused the durth. Do not enter the mode shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition and the cause of the cause o frying, such as cardiac or respiratory arrest, Approximate Interval Between Onser and Death not Physician/ disease or condition resulting in death) Medical Due to (or as a crins quince of) Examiner Sequentially list conditions, if any, recomp to innectate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or se's consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) 1 Yes 2 9 Unknown 2 🗌 No detached completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Yes 2 A 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 17/146 ည 1 Tes ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending death. 2 Accident
3 Suicide 2 🗆 No Investigation n 24 hours after deat e Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 the and title of certifier 29b Signature 29d. Date signed (Month, Day, Year)

Registrar

State

DHMH 17 Rev 7/2009

SMITH XVE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835

32. Registrar's Signatur

MENNITT

31. Date filed (Month, Day, Year)
OCT 2 7 2010

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TIEM 20b, c. per FH, G908, 1072972010, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 1: 15AM 24 2010 Todd Glenora /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** BALTIMORE HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min Days 1 ☐ M 2 ☐ XF Yrs **Director** 22 56 03 MD 218-60-5614 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show s 23a or 28a-f shoviust by rotified at 1 Yes 2 □ No Director MD NA Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number items 23a U.S.A. 21206 Funeral 4628 Asbury Ave 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status or other traumatic event, the Modical Exaction 1 Never Married 2 Married 1 Yes 2 No If 4es, Give Year or Dates: Baltimore, Maryland 21215-0036 9 1 ☐ Yes 2 ☐ No Specify: þ Specify: Black "natural", 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker King Sealy 12th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be 1 Department of Health and Mental Important: If Item 27 is marked of Wes Todd Lettie G. Meachurn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4133 West Forest Park Ave, Baltimore, Linda Banks-Sister Date Ukn 20c. Location - City or Town, State Owings Mills Baltimore, Md 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place): 11 1 □ Burial 2 □ Cremation 3 □ Removal from State Injury o Garrison Forest Vet. 11/5/2010 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licensee Signa 22. Name and Address of Facility March F/H West Ju. 3a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho x, or heart failure. List only one cause on each line.

Introduction Cause (Final disease or condition resulting in death)

a. Baltimore, Md 21215 Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) certificate be executed SACRAL and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial SEPSIS Physician/Medical yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) been signed by the should be detached 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has director, page 2 s autonsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☑ No 1 Tyes Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Crititying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the the To the within 7 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) eh 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL. 900 CATON ANG BALTIMORE, MD. AGNES 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 33680 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Herbert Horatio Tyler Jr. Oct<u>ober</u> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Harford If Under 24 Hrs Hours Min. 9. Birthplace (State or Foreign Country) New Jersey Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🔀 M 2 🗆 F Days (Month, Day, Year) Months Director 149-16-1552 June 86 Usual Residence of Decedent 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland Harford Bel Air ់ 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral , or items 23a 1816 Lear Court 21015 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced Specififican American 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Funeral Director <u>Mortuary</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herbert Horatio Tyler Sr. Irene (unk) Booker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it. Page 1 and 2 s Department of Health Important: If item 27 Helen D. Tyler / Wife 1816 Lear Court, Bel Air, Maryland, 21015 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Clarks UMC Cemetery | 10/23/2010| Bel Air, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death intracerebral Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last ending physician a use as the burial-Physician/Medical Box 68760 attending p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Month Day Year ed by the a detached f o signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed After this certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Funeral L Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of Certifier 29c. License number 29d. Date signed (Month, Day, Year) Uctober 21,2010 Um 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Upper Chesapeake Drive Bel Air, MD 21014 32. Registrar Registrar

MSOOSUBGE

DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month MICHAEL 2010 CHARLES OCTOBER 7:45 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 2909 Ady Road Forest Hill Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral New York Days NOV . I 1931 1 M 2 □ F Hours 064-26-4493 Director 78 Usual Residence of Decedent or 28a-f show 10a. State 10b. County should be filed within 72 hours after death with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2909 Adv Road 21050 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian 1 Never Married 2 Married Completed by 1X Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' any injury or other traumatic event, the Me Aircraft Elementary/Seconday (0-12) College (1-4 or 5+) Stationary Engineer Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Carmello (nmn) Tama Rose (nmn) Vetrano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael J. Tama Sr. / Son Page 1 and 2 2907 Ady Road, Forest Hill, Maryland, 21050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Bel Air Memorial Gdn. 10/29/2010 Bel Air, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. Wivas C 50 W. Broadway, Bel Air, Maryland 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Coronary disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury iis certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) 2 No 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate I 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes s after death 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town. State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practigher: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 006398 2010 MD 30 Name and address of person who con Benjamin Lee, mp pleted cause of death (Item 23a) (Type, Print) Havre de Grace 669 Revolution 21078 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #23b Per Phy G908 10/27/10 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 33682 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month October ZZ\_ Physician/ 2 010 Christine Wood 6:50 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sinai Hospital Baltimore . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) New York 1 - M 2 - F (Month, Day, Year) Months Days Hours Min. 100-16-9188 8 Director 7 March Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exa<u>miner must be notified at</u> 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Owings Mills 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death with 2725 Baublitz Rd. 21117 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes XX No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: If Yes, Give White XXWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Home Maker Own Home Page 1 and 2 should be filed with ment of Health and Mental Hygie ant: If item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unknown 2 Edna Edward Springe1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward J. Wood / Son 2725 Baublitz Rd. Owings Mills, MD 21117 or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott A11 Faiths Crematory 10/26/10 1 Burial 2XXCremation 3 Removal from State 4 Donation 5 Other (Specify) Manchester, MD Chape1 P.A. 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. MD211 21. Signature of Un I Service Licenses 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Pulmonary Arrest Cardio disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner colon Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or linjury that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): attending physician I for use as the buria ledical To the Hospital or Attending Physician; The law requires that the death certificate be P.O. Box 68760 Physician/M IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown the cate has been signed by page 2 should be detac Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 2 🗌 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. H68214 October 25 2010 0.0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yaniv Berger 2700 Quarry Lake Drive Suite 280 Baltimore MD 21209 32. Registrar's State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 9 OCTOBER VIRGINIA WHITE 6:45 PM LOUISE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 8. Date of Birth **Funeral** Country) MD. 1 🗆 M 2 🗷 F Days Hours Min. Months 217-32-7074 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD FREDERICK 1 Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? iner must be Funeral Phebus 21701 USA 262 Page 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married þ 2 No Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: BLACK "natural", 3 Widowed 4 Divorced Completed al Hygiene. d other than "naturs event, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) PRIVATE FAMILIES Elementary/Seconday (0-12) College (1-4 or 5+) SOMESTIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked or ARDELLA WELDON JOHN CLAYTON WHITE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 1153A ORCHARD TERRACE APTIOI FREDERICA MD 21703 WILLIAM Thomas White 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State FREDERICK MD 047,27,2010 4 ☐ Donation 5 ☐ Other (Specify) FAIRVIEW COM 22. Name and Address of Facility GARY L. ROLLINS PW. Ifm E 21. Signature of Funeral Service Licensee, Rolle suy 2. PREDERICH MD 110 WOST SOUTH ST 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Cerebro Vascular Accident Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any most substantial cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physiclan the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 4 ☐ Pregnant at time of death g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 **X** N 2 🗌 No 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: Certificate: To 1 N Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be within 24 hours a er de To the Funeral Directo completed filled i by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Norse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Dy 3091 10-20-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rosed Caidi HO 801 Tou House Ave, Frederick, MO 21701 31. Date filed (Month, Day, Year, OCT 27 2010 32. Registra 's Signature State

Registrar

Barks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryl		irtment of H <i>tificate of D</i>			iene <sub>eg. No</sub> ? ()	0 33684
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	Examin	er	Seasons Hos	,		4b. City, Town, or Randall			4c. County of D	
	Funeral		5. Social Security Number 6. Sex	7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9.	Birthplace (State or Foreign
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	land show dat	tor	10a. State 10b. County	10c	. City, Town or Loc					10d. Inside City Limits
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	ith the	Funeral Director	10e. Street and Number 4208 Ridgewood Avenue			10f, Zip Code	21215	1	0g. Citizen of What U	Country? .S.A.
	eath w		merican Indian,							
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 3 🙀 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.		Yes, specify Cubar  ☐ Yes 2 🌂 No		rican, etc.)	Black, W Specify:	/hite, etc. Black
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Ma	Ith and 27 is r r traur		19a. Informant's Name/Relationship (Type  Marc Williams	e, Print)	19b. Mailin	g Address (Street a 2 <mark>08 Ridgewoo</mark>	nd Number or Rura od Avenue Ba	altimore, Mai	City or Town, State, yland 21215	, Zip Code)
Jre,	1 and of Hea fitem		20a. Method of Disposition		Db. Place of Dispos	sition (Name of eatory or other place		1	20c. Location - City	
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P.0	s that t gned b	by	Part II. Other significant conditions con	tributing to death but no	t resulting in the ur	nderlying cause give	en in Part I.		_	e to the cause of death?
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Division of Vital Records, P.O.	e has b	Completed						24a. Was ar autops perforn	y prior deat	
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ξ	hysici his ce al direc	은	T LI Yes 2 LY NO		2 ER/Outpatien				nce 6 Other (S	pecify) his yuce
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<u>S</u>	ottal or urs aftu rral Dir Illed in		#	1						
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affer death.  Of the Funeral Director: Affer this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2   Medical Examine	cian: To the best of my kier: On the basis of examin Practioner: To the best of	nation and/or investi	igation, in my opinio	n, death occurred a	the time, date and	d place, and due to t	the cause(s) and manner stated.
_	Vithi Vom	_	29b. Signature and title of certifier	11		29c. License	number	2	9d. Date signed (Me	onth, Day, Year)
			30 Name and address of across who are	mpleted cause of death	(Itom 22a) /T D	1004	77/3		763/2	2 - 6
			30. Name and address of person who con KALEN W METULITY	2835 ST	1.711 V	FUITE	203 13	Herirech	E MIN Z	1707
	Stat Registra	e	31. Date filed (Month, Day, Year)  OCT 27 2010	32. Registrar's S	gnature	1				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 3 per dr., g908, 10/28/2010dhb Certificate of Death Reg. No. State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER 4:07a LAURA 2010 JANE WILKERSON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death SOUTHERN MD HOSPITAL CENTER CLINTON PRINCE GEORGE'S Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 9-13-1925 Days Min 1 □ M 2√2 F 579-28-4683 Director 85 Ν. Usual Residence of Decedent ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD. CHARLES WALDORF 1 🗌 Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10945 BERRY ROAD 20603 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 2X Married 2 X No Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2X No Specify: If Yes, Give 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 10th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) <u>0</u> MAURICE PHIFER FOSTER MARY AMANDA BOBBITT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LARRY WILKERSON-SON MILL HILL RD. WALDORF, MD. 20603 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or outer pieces,
TRINITY MEM.GARDENS 10-15-10 WALDORF, MD. 22. Name and Address of Facility RAYMOND FUNL. SERVICE, 21. Signature of Furneral Service Licenses M00479 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Oue to (or as a consequence of transit or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) eral Director. After this or utificate has been signed by the attending physician a filled in by the funeral dire tor, page 2 should be detached for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 🔲 Yes 2 📈 No 5 Other (specify) Month Year Day 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tes 2 No ပ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours aff Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

10

Registrar

State

30. Name and address of person

31. Date filed (Month, Day, Year

OCT

27 2010

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the completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 33686 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** Williams 2010 DCT. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 13 BEL AIR HEALTH AWD REHAAILITATION CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye March 28, 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. **Funeral** Days 1 □ M 2 → F Months Hours 87 215-32-8710 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, <u>the Medical Examiner must be notified at</u> 1 ☐ Yes 2 ☑ No Ellicott City Maryland Howard Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21042 USA 9365 Furrow Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White Baltimore, Maryland 21215-0036 δ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frazee Benjamin Chaffman Maude F. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any Injury or other trau once. 9365 Furrow Ave., Ellicott City, MD 21042 David W. Williams (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Loudon Park Cemetery 10/26/10 |Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licenece 3620 Wilkens Ave., Baltimore, MD 21229 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and De Immediate Cause (Final disease or condition resulting in death) DADNU 1-la **Physician** /Medical Due to (or as a conseq ence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Eriter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions conditioning to death but not resulting in the underlying cause given in Part I. or Vital Records, Completed by 3 ☐ Probably 4 ☐ Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perforn certificate 1∐ Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Nursing Home Hospital: 3□ DOA 1 ☐ Inpatient 2 ☐ ER/Outpatient 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 TYes 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Deat Division 5 Pending investigation Injury ☐ Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ō within 24 hours a Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated. 29a. Certifier Medical he basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. 29d, Date signed (Month, Day, Year) ture and title of ce ame and address of n who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State OCT 27 2010

**ORIGINAL** 

Registrar

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State of Maryland / Department of Health and Mental Hygiene   Certificate of Death   Reg. No.	0-07619		Discos	<b>T</b>	Duint in F	21 - a la las	اطناءا	a lade	Enous	. All Cani	ioo Ara I	المانده			
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Second Comment   Seco	th the Ma 23a or 28 notified	Dire		lio Cou		·- · ·									La Charles
Physician    Approximate Interver Season of Control of	r death wi	Funer	1 Never Married 2		Armed Force	s? 2 No		If Yes, sp	ecify Cuba	n, Mexican, Puen		NO-	White,	etc.	
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Failure List only one cause on each line.    Sequentially list conditions are unique that inflated course (Final death)   Due to (or as a consequence of):		-	23á. Part I. Enter the dise	ase or compl	ications that cause	ed the death.		4308	Suit	lnad Rd.	Suit1	and,	MD Z	0/4	ο
or condition resulting in death)  Due to (or as a consequence of):    Due to (or as a consequence of):	Medical		failure. List only one	cause on ea	ch line.				, ,						Between Onset and Death
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The second secon	ox 68 th certifi ttending or use as t	sician	past 12 months?		4 Pregnant	at time of de	oth =			Ectopic pregr	nancy		Month	Da	ay Year
The second secon	J. Bc t the des by the a				1	ath but not re	esulting in	the underly	ving cause	given in Part I.	23e. Did	tobacco	use contribu	ute to ti	ne cause of death?
The second secon	s, P.( iires tha signed d be det	ğ İ													
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29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	thin 24 hou the Fune the fune mpletely fi		29a Certifier 1 Certify		On the basis of ex	camination a									
	7 × 5 8	Me	29b. Signature and title of	certifier	and manner states	<u>.                                    </u>							_		th, Day, Year)

State 31. Date filed (Month, Pay Year) OCT 1 4 2010 Registrar

Donna M. Vincenti, MD Assistant Medical Examiner 32. Registr 's Sign ture

30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Mar		tificate of Dea			g. No.	33688
	Physicia		1. Decedent's Name (First, Middle, Last)  Desta Kibru Ali				2. Date of Death Month October	Day 2010	3. Time of Death 1:00 P. M
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Loc	cation of Death	OCTOBEL	4c. County of Death	1:00 P. "
•			Washington Adventist Hosp			a Park		Montgome	
	Funeral Director		1 N 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(In yrs. last birthday) 79 Yrs.		Under 24 Hrs. lours Min.	8. Date of Birth (Month, Day, Y October		place (State or Foreign htry) niopia
	and show dat	ē		10d. Inside City Limits					
	Maryl 28a-f otifie	Director	District of Columbia	Washi	ngton 10f. Zip Code				1 X Yes 2 No
	g. Citizen of What Cou								
	Ethiopia  14. Race - Americ	can Indian.							
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatte event, the Medical Examiner must be notified at ance.	Completed by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ♣ No 1 ☒ Widowed 4 ☐ Divorced 1 ☐ Yes, Give Year or Dates.	n	Vas Decedent of Hispa f Yes, specify Cuban, M Yes 2 <b>X</b> No S		Rican, etc.)	Black, White, Specify <b>Ethic</b>	etc.
5-0	2 hour "natu	plet	15. Decedent's Education (Specify only highest grade completed)	(Give I	lent's Usual Occupation	na most of working	a	6b. Kind of Business In	
21215-0036	ithin 7 iene. r than the Me	Com	Elementary/Seconday (0-12) College (1-4 or 5+)  8th grade	Chief	NOTuse retired) of Branch Finance	for Mi	nister	Ethiopia (	Covernment
1d 2	filed will all Hygid of the control	Be	17. Father's Name (First, Middle, Last)	01			(First, Middle, Ma		30veriment
ylar	ld be fil Mental arked o	욘	Ali Kibru				nu Defe		
Maryland	2 should Ith and Me 27 is mar		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and	Number or Rural	Route Number, C	City or Town, State, Zip	Code)Maryland
	and 2 Healt Item 2		Ameha Desta (Son)  20a. Method of Disposition	20b. Place of Dispos	sition (Name of	-		05;Silver S	Spring, 20910
Baltimore,	permit. Page 1 a Department of H Important: If Ite any injury or of		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, cren	natory or other place)  Church Ce	Oct.1	6.2010	ddis Ababa,	
Balt	permit. Depart Import any inj		21. Signatura of Funeral Service Licensee						Morticians, on,D.C.20011
П			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.						Approximate Interval Between
-	Ph sician/		Immediate Cause (Final disease or condition resulting in death)	Work	CAN	Cert			Onset and Death
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		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	onsequence et:	-1 // =	10-1	7		
	cuted ind transit	Examiner	Cause (Disease or iinjury that initiated events c.	1460	701477	o Cert		_	
	death certificate be executed the attending physician and ed for use as the burial-transit		resulting in death) Last Due to (or as a a	sonsequence of	M = 4	_			
3760	ficate to g phys	ledic	d	1					
89 ×	eath certifica attending p	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of 1 Live Birth 2		Ectopic pregnancy			23d. Date of deliv	ery
. Box 68	t the deat by the at tached fo	Physician/Medical	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at ti 9 ☐ Unknown 9 ☐ Unknown		Other (specify)			Month	Day Year
P.O.	that the	by PI	Part II. Other significant conditions contributing to death but	not resulting in the u	nderlying cause given i	n Part I.	23e. Did toba	cco use contribute to the	ne cause of death?
ds,	v requires that been signed k should be det	ted					1 🗆 Yes	2 No 3 Pro	bably 4 Unknown
Division of Vital Records,	The law recate has be page 2 sh	Completed					24a. Was an autopsy perform	prior to co	psy findings available mpletion of cause of
Ĕ E	slcian: The certificate rector, pag		25. Was case referred to medical		26 Place	of Death (Check	1 ☐ Yes 2		2 No
Ĭ.	Physician: this certific ral director,	To Be	examiner? 1 Yes 2 No Hospital:	t 2 ER/Outpatien	_ Other			ce 6  Other (Specify	)
Jo (	ding Pt th. After th funeral		27. Manner of Death  1 Natural 5 □ Pending  28a. Date of injury (Month, Day, Y	(ear) 28b. Time of injury	28c. Injury at work?	1	8d. Describe how	injury occurred	
sior	I or Attendi after death. Director: A I in by the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	- At home, farm, stre		2 🗆 No	Of Location /Stro	et and Number or Rural	Pouto Number
<u> </u>	al or A s after il Direc ed in by		4 Homicide determined		ot, factory, office		City or Town,		noute Number,
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral bifers dear After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of exam	mination and/or investi	igation, in my opinion, d	leath occurred at 1	he time, date and	place, and due to the ca	use(s) and manner stated.
	o the	Me	only one) 3 Certifying Nurse Practioner: To the be	st of my knowledge, d	eath occurred at the tim	ne, date and place	, and due to the ca	ause(s) and manner as st	ated.
	r s F o		1 Comment	MiD.	100	613	7	October 8,	
	att		30 Name and address of person who completed cause of deat	th (Item 23a) (Type, P	rint) DAZ	To the	ENE	JULEN.	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland Department of Health and Mental Hygiene

		•	For Amend Items Registrar				27/72010a tificate of	Death	Re	g. No 2011	0 33689
	Physicia /Medic	_	1. Decedent's Name (First Middle, La	Allan Fore	st Arms	trong	1		2. Date of Death Month	Day Ye	
	, Examin	100	4a. Facility Name (If not institution, given		Saw I			Location of Death		4c. County of E	leath
	Funeral Director		5. Social Security Number 6. 3 2 3 5 2 0 8 3 6 4	Sex 7. Age	(In yrs. last 85	birthday)_ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 2/4/1925	Year) 9. Ter	Birthplace (State or Foreign Country) ra Alta, W
	land ow It		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Loc	ation				10d. Inside City Limits
	a-f she	ctor	WV Preston		Bruce	ton Mi	lls				1 ☐ Yes 2 🙀 No
	or 28	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of What	Country?
	eath w	Funeral	Rt 4 Box 21 11. Marital Status	12. Was Decedent E	ver in U.S.	13 W	26521	ispanic Origin? (Sp		US 14. Bace - A	American Indian,
036	should be filed within 72 hours after death with the Maryland and Mental Hygene.  Transked other than "tratural", or Items 23a or 28a-f show marked other than "tratural", or Items 25a or 28a-f show marked other than "tratural", or Items 25a or 28a-f show marked other than "the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	Armed Forces? 1 ⊠Yes 2 □ N If Yes, Give Year or Dates:		1	Yes, specify Cuba  ☐ Yes 2☑ No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)		Vhite, etc.
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ylar	ould by Menta arked atic e	To E	Charles Roundy Armsti					Geneva Alf	2 3		
Maryland	d 2 should th and Men 7 Is marke traumatic		19a. Informant's Name/Relationship	, • ,			-	and Number or Rui		City or Town, Sta	te, Zip Code)
	is 1 and 2 should of Health and Mer item 27 is marke other traumatic		Maynard Armstrong / So 20a. Method of Disposition	on	20b. Place	e of Dispos	sition (Name of			20c. Location - City	/ or Town, State
E C	it. Pages intent of intent; If its injury or o		1 ☐ Burial 2 ☐ Cremation 3 [ 4 ☑ Donation 5 ☐ Other (Spec		W Sci Medic	nool of ine -	etory or other plac f Osteopath Human Gift	îÎc   9/30/	2010 Le	ewisburg, V	₩
Baltimore,	permit. Page Department of Important: If any injury or once,		21. Signature of Funeral Service Lice	Jandy Har		22.	. Name and Addre	ss of Facility WV-	School of (	Osteopathio 901	Medicine
			23a. Part1 Enter the disease of cor	nplications that caused	the death. [				J.		Approximate
	Physician	6 17	shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each lin	e.	s.f.	7.60 K	Sonal D	)		Interval Between Onset and Death
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	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	200.000	2 001100 44011	.00 01/1					
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.O. Box 6	sath cer attendin for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome p 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal de	eath 3 🗆	Ectopic pregnancy Other (specify)	/		23d. Date of Month	
S, D	w requires that the de been signed by the s should be detached	by	Part II. Other significant conditions	contributing to death bu	ıt not resultin	ng in the un	derlying cause giv	en in Part I.			te to the cause of death?  ☐ Probably 4 ∑Unknown
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	Physi r this c ral dir	٠ <u>.</u>	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 ☐ Inpatie		Outpatient  Bb. Time of	t 3 DOA Oth	4 □ Nursing H	ome 5 Reside	nce 6 🖾 Other (	Specify)
0	nding P uth. r; After e funera	ation	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day		Injury	28c. Injur Wor M 1 □	k? Yes 2 □ No		,,	
Division or	al or Attendations after death	Certification:	3 ☐ Suicide 6 ☐ Could not to determined		iry - At home c. (Specify)	e, farm, stre	eet, factory, office		28f. Location (Str City or Town		or Rural Route Number,
	To the Hospital or I within 24 hours after To the Funeral Directional Direction of the Funeral D	Medical (	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exe	hysician: To the best of the miner: On the basis of and manner sta	examination	edge, death n and/or inv	occurred at the tile restigation, in my	me, date and place opinion, death occu	, and due to the ca rred at the time, da	ause(s) and manna ate and place, and	er as stated. If due to the cause(s)
	To the within 2	Ž	29b. Signature and title of certifier				29c. Licens	e number	29	d. Date signed (A	Month, Day, Year)
			20 Name and addison a		1	3-) (T: - : -	Print)	4/9/	5	9/30/2010	
		•	30. Name and address of person who	mer (	) [//		311	North of H	h street	- caklu	MP 2(55)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33690 StateRegistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 06. Sylvia 2010 8:22p M Braverman Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Renaissance Gardens - Riderwood Silver Spring Prince George's 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🏿 F New York Months Davs Hours Min. nth, Day, Year) /28/1922 Director 075-12-0622 88 Usual Residence of Decedent if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Silver Spring Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3160 Gracefield Road 20904 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces' Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Abraham Kirschner Bessie Waller Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce Braverman - Son Schindler Court. Somerset. New Jersey 08873 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 X Removal from State 4 Dopation 5 Other (Specify) Beth Israel Cemetery 10/08/2010 Woodbridge, New Jersey Funeral Service Licensee 21. Sign xure of 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. M0070 1800 New Hampshire Ave., Silver Spring, MD 20904 ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the dis Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician/ disease or condition resulting in death) Cardiovascular Accident Medical Due to (or as a consequence of): Examiner Atrial Fibrillation Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on been signed by the attending physician and should be detached for use as the burial-transport law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant Unknown Year Pregnant at time of death 5 Other (specify) 2 X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vascular Dementia Records, 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Diabetes Mellitus within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s Yes 2 X N 25. Was case referred to medical examiner?
1 ☐ Yes 2 XX No Hospital or Attending Physician: 26. Place of Death (Check only one) Other: Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 X Nursing Home 5 Residence 6 Other (Specify) Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 X Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) ည 29d, Date signed (Month, Day, Year) 10 D0036716 October 7, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD, Andrew George Kundrat, 3110 Gracefield Road, Silver Spring, Maryland 20904

State Registrar 31. Date filed (Month, Da

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Registrar's Signa

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 735 AM largas OCT 2010 Medical 4a. Facility Name (if not Institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death salti more UMMC If Under 1 Year | If Under 24 Hrs. . Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 😾 F 224-48-3587 84 067277926 Germany Director Usual Residence of Decedent 28a-f shov ral", or items 23a or 28a-f shorex Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel 1 🗌 Yes 2 ី No Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7704 Pear Ave. 20794 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: If Yes, Give 3 😾 Widowed 4 🗆 Divorced White Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 02 <u>Homemaker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Johann Vitus Franziska Mueller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank H. Bailey 2179 Richardson Road Westminster, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 10/10/10 Glen Burnie,MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility 851 Annapolis Road Gambrills, MD 21054 Oatru Hardesty Funeral Home P.A. 23a. Part 1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Massive tracerebra disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): sician and burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ 23d. Date of delivery in the past 12 months?

1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the sid be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy Yes 2 No 1 Yes 2 No **Director**; After this certific in by the funeral director, 25. Was case referred to medical | a 26. Place of Death (Check only one) Hospital 2 🔀 No မြ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending I 24 hours after death. injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical Knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 9900 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Crandall S. Greeve St. Beltimore MD M.D 21201 gistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33693 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10/8/2010 Homer David Baker 12:50pmM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Heritage Harbour Health & Rehab Annapolis Anne Arundel . Social Security Number . Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** txEx M 2 □ F Months Days Hours Min. 73 (Month, Day, Year, 8/19/193) 522-44-1954 Director CO Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director MD 1 Yes 2 No Prince George Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3850 Enfield Chase CT. 20716 Apt. 208 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, was becedent Ever in U.S. Armed Forces? 1√√ Yes 2 □ No If Yes, Give Year or Dates.1961–1997 Black, White, etc Completed by 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: White Specify: 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Officer U S Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Homer Ray Baker Virginia Rhea 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt. 208 Bowie, MD 20716 Christopher Baker Wife 3850 Enfield Chase CT. 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial ※XX Cremation 3 ☐ Removal from State 10/12/2010 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 21. Signature of Funeral 6 22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner Due to jor as a consiguence of if any leading to immedicause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 F FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

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To the Funeral Director: After this of the funeral diled in by the funeral diled in by the funeral diled in the funeral diled i 1 Inpatient 2 ER/Outpatient 3 DOA rsing Home 5 Residence 6 Other (Specify) 27. Manner of 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred C. Nedural 5 Pending work 1 Yes 2 🗌 No Accident Investigation 3 Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

State Registrar 30. Name and address

31. Date filed (Monti

rerson who completed cause of death (Item 23a) (Type, Print)

2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ October 1 3 11:42 AM 2010 Sara Jane Blake Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cecil Union Hospital of Cecil County E1kton 9. Birthplace (State or Fereign Mary land 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 21, Year 923 Days Min. 1 □ M 2 **X** F 87 **Director** 215-18-6604 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director North East 1 X Yes 2 ☐ No Cecil Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21901 319 East Cecil Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXNo Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give White Maryland 21215-0036 1 ☐ Yes 2XXNo 3 ☑ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Supply Clerk Government 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Essie Nowland Jesse Alexander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coo 177 Plum Creek Road, North East, Maryland 21901 Joyce Slagle / Daughter Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition October 15 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Nofther East oundiredce North East, Maryland 2010 Methodist Cemetery 22. Name and Address of Facility Crouch Funeral Home neral ervice 127 South Main Street. North East. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ inknown disease or condition resulting in death) Medical Due to (or as consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or se's consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Records. Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe 1 🗌 Yes 25. Was case referred to medical examiner?

1 Yes 2 Division of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ျှ . Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funeral Directo completed filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical tifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day 29b. Signatur

State Registrar DHMH 17 Rev 7/2009 31. Date filed (Month.

Day, Year)

e and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 700 3010 /Medical 4a. Facility Name (If not institution, give street and number) County of Death 4b. City, Town, or Location of Death **Examiner**  Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Min 1 □ M 2 F Hours 557-50-362 Yrs HI Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director MD Ceci1 E1kton 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number ö "natural", or items 23a 100 Laurel Drive 21921 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No White Specify ģ Specify: 3 ☐ Widowed 4 🎇 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Newspaper Librarian Newspaper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Myron Alton Everett Margaret McCarthy ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If item 27 is any injury or other trae William Everett/ Brother 113 High Country Drive Cary, NC 27513 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 10/15/2010 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Foard Funeral Home, P.A. Rising Sun, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
R.T. Foard Funeral Home, 259 E. Main St. Elkton, MD 21921 23a. Part 1. Enter the disease, or complication t at cause, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cars on each life. Immediate Cause (Final archioreshirat **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events Due to (or as a consequence of) Examiner burial-transi resulting in death) Last Due to (or as a consequence of) Physician/Medical eeul IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 Ist No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performe 1 ☐Yes 2 ☐ No 1 □Yes 2 🖳 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred **Matural** 5 ☐ Pending investigation 1 ☐Yes 2 ☐No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Box 68760 P.O. Division of Vital Records,

The law requires that the death certificate be executed physician at the burial attending properties for use as signed by the a should b certificate has be rector, page 2 sl To the Hospital or Attending Physician: After this c within 24 hours after ucc...

To the Funeral Director: Aft

with the Maryland

filed within 72 hours after death

and 2 should be

Baltimore, Maryland 21215-0036

Registrar

State

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

10-14-10

30. Name and address of person who use of death (Item 23a) (Type, Print)

onth, Day, Year,

DHMH 17 Rev 1/2001

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DeZern

Amy

RES-000

October 3 2010

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3697 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10/01/5010 Larry Darnell Bell AM 2:13 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Temple Hills 3001 Branch Ave. <u>Prince George's</u> Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ■ M 2 □ F Months Days Hours Min (Month Day Year) Director 234-90-9213 06/25/1954 Usual Residence of Decedent 28a-f shov ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Temple Hills 1 X Yes 2 No MD Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral AZU 3001 Branch Ave. 20748 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Civil Engineer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental h မ age 1 and 2 should be ent of Health and Ments It: If item 27 is marked y or other traumatic e Cumy Dixon Jessie Morris Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victoria Savage / daughter 3960 Pennsylvania Ave. apt. 107 SE<sub>l</sub>Washington DC20020 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) lo/09/20ld Bluefield, WV Restlawn Memorial Cem 21. Signature of Funeral Service 22. Name and Address of Facility Strickland Funeral Services 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician ma disease or condition Medical resulting in death) Due to (or as a equence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director. After this certificate has been signed by the attending physician and seried filled in by the funeral director, page 2 should be detached by use, as the burial-transit elect filled. Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 ☐ No 3 💢 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 🗌 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. прieted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) De MONACO 31. Date filed (Month, Day, Year) State

Registrar

DHMH 17 Rev 7/2009

2 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER ANNIE BELCHER 2010 12:40 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death MANOR CARE NURSING HOME PRINCE GEORGE'S LARGO 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 1 🗆 M 2 🗔 Months Hours Min (Month, Day, FEB 12 Yrs. SOUTH 579-32-7775 92 Î918 Director CAROLINA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits **Funeral Director** 28a-f 1 🛚 Yes 2 🗆 No MD PRINCE GEORGE'S UPPER MARLBORO 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? 23a 1606 YUHAS COURT 20774 USA Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc ģ 1 Never Married 2 Married Yes 2 No SHEIMER' Descentimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify. BLACK "natural" Specify. Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 7TH HOUSE KEEPER PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked or ည GARFIELD CRAWFORD JOSEPHINE GARY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. BARBARA BOWIE/DAUGHTER 1606 YUHAS COURT UPPER MARLBORO, MARYLAND 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State RIVERDALE CREMATORY 10/12/2010 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE, MARYLAND 21. Signature of Funeral Service Licens 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused net eath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ADVANCED ALZHEIMERS DISEASE Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 XNo g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 😾 No 3 ☐ Probably 4 ☐ Unknown Was a.. autopsy performed? Vas 2 12 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an as Sec certificate ha irector, page 2 1 Yes 2 XNo å 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 🔀No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 $\times$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury 1 Yes 2 No ☐ Accident ☐ Suicide Investigation Director: , 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number,

Box 68760 Division of Vital Records, P.O.

State

Registrar DHMH 17 Rev 7/2009 29a. Certifier

(Check

only one) 29b. Signatu

BAHRAM PISHDAD M.D 31. Date filed (Month, Day, Year,

1328 SOUTHERN AVENUE SUITE 310 WASHINGTON, DC 20032

address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

OCTOBER 11, 2010

29c. License number

D51520

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 33699 State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** ROBERT SOMERSET COOKSEY 2010 4:56PM october /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Charles Medical Civista later 9. Birthplace (State or Foreign M Sountry) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Month, Day, gasty 219-72-4005 **№** М 2 Б 51 Director Robert MR354719 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at once. CHARLES LA PLATA 1 ☐ Yes 2 No MD. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20646 U.S.A. 8461 KENTUCKY AVE. Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Marylahd 21215-0036 1 ☐ Yes 2 ☐No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) COCA COLA Elementary/Secondary (0-12) College (1-4or 5+) BOTTLING CO. SALESMAN 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MARY LOUISE HARRISON HAROLD ROGER COOKSEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8461 KENTUCKY AVE. LA PLATA, MD. 20646 DIANA COOKSEY-SPOUSE Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
4 Donation 5 Other (Specify) METROPOLITAN CREMATORY 10-26-10 ALEX., VA. M00479 21. Signature of Funeral Service Licensee. RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) EREBROVASCULAR CCIDENT **Physician** /Medical Due to (or as a consequence of): Examiner ERTENSION Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1□Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ACEMENT 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 2 No Hospital or Attending Physician: director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 1 ☐ Yes in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled lled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

50 Post Office Rd

#306 Waldorf Maryland 20602

30. Name and address of person who completed cause of death (Item 23a) (Type, Print),

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Physician/ October 5. 2010 Harriet Cornelia Connolly 10:10 p M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Sandy Spring Friends Nursing Home 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 153–16–2016 **Funeral** 1 □ M 2 🖾 F Months Hours Feb. 9. Year 1920 New Jersey 90 Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State filed within 72 hours after death with the Maryland Director 1 Yes 2 No Derwood MD Montgomery 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral 20855 USA 19117 Artesian Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White If Yes, Give Year or Dates "natural", Completed 3 Wildowed 4 Divorced traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit, Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ည Cornelius Augustine McGlennon Harriet Seton McCabe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19117 Artesian Court, Derwood, MD 20855 Ann S. de Stwolkinski/Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 7 cemetery, crematory or other place) ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Metropolitan Crematory Alexandria, VA 2010 4 Donation 5 Other (Specify) 21. Signa re of Funeral Service Licenses 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Atherosclerotic Cerebrovascular Disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical I Division of Vital Records, P.O. Box 68760 IF FEMALE: asn 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☒No Month Year for Day Pregnant at time of death ed by the a Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Yes 2 No 3 Probably 4X Unknown Completed has been Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 Yes Yes 2 No 25. Was case referred to medical completed filled in by the funeral director. 26. Place of Death (Check only one) æ examiner? Hospital Other: 2 ANO 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) မြ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after death. I Director: After t Certificate: 1 Natural 2 Accider work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. vithin 2 the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number è October 7, 2010 D28595

State Registrar 31. Date filed (Month, Day, Year)

OCT

1 2 2010

. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Tasneen Lakhani, MD 2835 Smith Avenue, Suite 203, Baltimore, MD 21209

Amend#6 per FD State of Maryland / Department of Health and Mental Hygiene AACO Health Dept 10-fl2-10 KAH 1 = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ October 6 pay 2010 Year Susie G. Claibourn 9:47 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Annapolis Anne Arundel Medical Center Anne Arundel . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Days Hours (Month, Day, 1 220-28-5213 1931 Director Washington, D.C. Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director items 23a or 28a-f s her must be notified 1 Yes 2 No MD Prince George's Upper MArlboro 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20774 126 Queen Anne Bridge Rd. USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces 1 ☐ Yes 2 🖾 No If Yes, Give ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 N Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cook Restaurants Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harry B. Watkins Cora Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1805 NE Crain Hwy., Lolita Anderson / Daughter Bowie, MD 20716 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o cemetery, crematory or other place) 🛚 🔼 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) 110/13/2010 Davidsonville, MD Lakemont Memorial 21. Signature of Juneral Service 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part 1. Enter the or complications that caused the death. Do not enter the mode of lying, such as cardiac or respiratory arrest, st only one cause on each line. Approximate Interval Between shock, or hear Immediate Cause (Final Onset and Death Fhysician, disease or comition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? After this certificate has been signed by the attefuneral director, page 2 should be detached for Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 🔀 🗽 Certificate: To 1 Appatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred To the Hospital ... within 24 hours after death.

To the Funeral Director: Aft Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and the 29c. License number son who completed cause of death (Item (3a) (Type, Print) 31. Date filed (Month 1 2 2010 32. Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 33702 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ October 2010 Aris L. Colbert 2215 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 **X** M 2 □ F Days Hours Mar 2 Months Min. 1950 Maryland Director 60 214-52-9301 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a. State 10d. Inside City Limits 10c. City, Town or Location Director Marvland Anne Arundel Annapolis 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 810 Brooke Ct. Apt C 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates1 969 – 70 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2X Married 1 ☐ Yes 2X No Specify. Black "natural", Specify: Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Sanitation Worker City of Annapolis Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Hillary Colbert Ruth Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is, any injury or other traum Darlene Colbert(Wife) 810 Brooke Ct. Apt C Annapolis, Md. 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 10-14-10 Maryland Veteran Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Winname Reaches of Sacility Ons Mortuary, P.A. 21. Signature of Funeral Service Licensee Larry S, Rese MO 0483 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ End MRSA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir physician and the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical as t attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death been signed by the should be detached 9 Unknown a I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has page performed? death? certificate 1 Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 2 No Other: 1 Yes ပ 1 Impatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No nours after death.

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3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 10,2010 W 2005 7635 30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Monti

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#54

3altimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Month Dennis Courtney October 2010 .4 9:10 p.m. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 46820 Flower Drive Lexington Park St. Mary's 8. Date of Birth (Month, Day, Year) 10/01/1947 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Social Security Number If Under 1 Year If Under 24 Hrs Days Hours Min. 1 XM 2 □ F **Director** Yrs. 219-48-5321 63 Maryland Usual Residence of Decedent show 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 X No Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 46820 Flower Drive 20653 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 🗡 No Black, White, etc. 1 X Never Married 2 Married Completed by ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify. 3 Widowed 4 Divorced Year or Dates **Black** injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ James Alexander Courtney Lillian Marie Stevens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20653 <u>Tamara L. Gant/Daugh</u>ter 46860 Hilton Drive, Apt. 2824, Lexington Park, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) of 10/20/2010 | Helen, Maryland Peace Cem Signature Superal Servicensee

Edward N. Brinsfield 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Hollywood Road, Leonardtown, MD 20650 M00052 22955 Jr. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Ph\_sician/ Metastautic disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): attending physician and I for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy been signed by the atte should be detached for in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death 2 No. 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No L Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify)

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

After this certificate has To the Funeral Director; After this certific completed filled in by the funeral director, Certificate:

Medical 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and adar Jennifer Schmidt, D.O.

Manner of Death

5 Pending

Investigation 6 Could not be

determined

Natural

2 Accident

4 Homicide

29a. Certifier

(Check

28a. Date of injury (Month, Day, Year)

29c. License number

work?

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number.

28d. Describe how injury occurred

City or Town, State)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28c. Injury at

40900 Merchants Lane, Suite 205, Leonardtown, MD 20650

31. Date filed (Month, Day, Year) Registrar's Signature

Registrar

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

iniury

Date of Death
 Month

Day

33704

3. Time of Death

10.0	Physicia /Medic Examin	al
	Funeral	
	Director	

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

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Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr once.		21. Signature of uneral Service License			22. Name and Addre	DLTI		Funeral Ho								
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	20		30. Name and address of person who co	ompleted cause of death	(Item 23a) (T	vpe. Print)				1 )							
10	no			24035 Three			lywood. MD	20636									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend #7/8 per FH PGH 10/20 Gertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 5 Day 2010 Physician/ 8:20 Ρ Helen M. Cook Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Upper Marlboro 9402 Concord Drive If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days Hours Min. | (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1920 1921 **Funeral** 1 🗌 M 2 🍱 F Georgia **Director** 254-28-2151 88 89 Yrs Dec. Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Maryland | Prince George's Upper Marlboro 10e, Street and Number 10f. Zip Code Hygiene. other than "natural", or items 23a or out the Medical Examiner must be r 10g, Citizen of What Country? Funeral 9402 Concord Drive 20772 United States . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 2 X No ☐ Yes Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify: If Yes, Give 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Private is marked other aumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ it. Page 1 and 2 should be furment of Health and Menta ortant: If item 27 is marked njury or other traumatic e Inez Jones Ralph Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9402 Concord Drive Upper Marlboro, Maryland Karen L. Allen - Daughter permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20772 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ■ Burial 2 □ Cremation 3 □ Removal from State ober ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Brentwood, Maryland f Funeral S vice Lic Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 20019 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Betwee Immediate Cause (Final disease or condition Onset and Death Dementia al Theimers Ph\_sician/ years Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician is be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

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4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 s autopsy performed this certificate has 1 Yes 2 No 24 hours after death.

Funeral Director: After this certific leted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 KResidence 6 Other (Specify) 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury **Natural** 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Sulcide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🔏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. соmpleted 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) DO 33299 Cynthia M Dillioms, DO 10-8-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CYNTHA M WILLIAMS, DO 3720 Upton ST N.W. Washington, DC 20016

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year) OCT 1 2 2010

32. Registra 's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DENNIS WAYNE CLARK OCTOBER 10,2010 11:41A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **⊠** M 2 □ F Sept.9 Maryland Director 219-56-9883 61 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Frederick Walkersville 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral 9517 Dublin Road United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates.Vietnam 1 ☐ Yes 2X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Regional Engineer State Highway Admin. or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be fill nent of Health and Mental ant: If item 27 is marked ( ည F. Wayne Clark Leona Leatherman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vicky Clark / Wife 9517 Dublin Road, Walkersville, Maryland 21793 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Sunset Memorial Park 10/14/2010 Cumberland, Maryland 22. Name and Address of Facility
Stauffer Funeral Homes P. A.
1621 Opossumtown Pike, Frederick, Maryland21702 21. Signature of ineral Ser 23a. Part 1. Enter the disease, or complication of at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final ESUPHAGEAL Physician/ CANCER disease or condition Medical resulting in death) Examiner MALNUTRITION Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-Physician/Medical Box 68760 attending p for use as 1 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year P.0. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 N death? 2 🗌 No 1 Yes of Vital To the Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After Natural 5 Pending injury Division s after death. 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State within 24 hours a

To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and titi 29c. License number DUU63498 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lakhvinder Wadhwa MD 400 West 7th Street, Frederick, Maryland 21702 Lakiiv .....
31. Date filed (Month, Day,

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

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	•	For State Registrar		State o	t Marylar		artment of I rtificate of L		-	giene Reg. N2	010	33707
Physicia		1. Decedent's Name (Fin							2. Date of De Month Octobe	ath Day		3. Time of Death 3:40 P M
Medic Examin		4a. Facility Name (if not	institution, give	street and num			4b. City, Town, o	r Location of Deat		4c. C	County of Deat	
Funeral Director		5. Social Security Numb	per 6. S	ex M 2 $\square$ F	7. Age (In yrs. i	Vre	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da Sep. 18	th	9. Bir	thplace (State or Foreign untry) PA
yland f show ed at	tor	Usual Residence of Dec 10a. State 10a	b. County		y, Town or Lo	cation					10d. Inside City Limits	
ith the Mar 23a or 28a- st be notifii	Funeral Director	MD 10e. Street and Number		c k	Wa	1kersv	10f. Zip Code 21793			10g. Citiz	en of What Co	1X☐ Yes 2 ☐ No ountry?
permit. Page 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene.  The manual transport is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status  1 Never Married  3 Widowed 4	2x Married	12. Was Dece Armed For 1 🛣 Yes If Yes, Give Year or Da	2 No		Was Decedent of H If Yes, specify Cuba	an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	1-	4. Race - Ame Black, White pecify: Wh	e, etc.
thin 72 hours sne. than "natur se Medical E	Completed by	15 (Specify Elementary/Seconda	5. Decedent's E only highest gra	ducation		16a. Deced (Give life. D	dent's Usual Occup kind of work done of O NOT use retired)	during most of wo	rking		d of Business	
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nd 2 should salth and M n 27 is mai er traumat		19a. Informant's Name/				19b. Mailir <b>37</b> N	ng Address (Street Main St.	and Number or Ru Walkersv	iral Route Numbe ille, MI	r, City or T	own, State, Zij	o Code)
t. Page 1 ar tment of He rtant: If iten ijury or oth		20a. Method of Disposit  1 Burial 2 C  4 Donation 5	Cremation 3 ☐ ☐ Other (Specif	ý)	State	emetery, crer Lade Ce	osition (Name of matory or other place emetery	10/1	Date 3/2010	Wall		lle,_MD
permi Depar Impor any ir		21. Signature of Funeral	CC.	m	yer	$\sim$ 10	2. Name and Addre	umtown P	ike, Fre	ederi		
hysician/ Medical Examiner		23a. Part 1. Enter the d shock, or heart fai Immediate Cause (Fina disease or condition resulting in death)	ilute. List only o	a.	aused the deat ch line. or as a conseq	mer	, 1	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
executed an and rial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C. Due to (or as a consequence of):										
the hospital or <b>Attending Physician:</b> The law requires that the death certificate be execut within 24 hours after death.  To the <b>Funeral Director:</b> After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transpace of the completed filled in by the funeral director, page 2 should be detached for use as the burial-transpace of the completed filled in by the funeral director, page 2 should be detached for use as the burial-transpace.	Physician/Medica	IF FEMALE: 23b. Was decedent pregint the past 12 monto the past 12 monto the past 12 monto the past 10 monto the past 10 monto the past 12 monto the past 1	ths?		Birth 2 🗀 Feta nant at time of	aldeath 3	Ectopic pregnand Other (specify)	су		23	3d. Date of de Month	ivery Day Year
lures that then signed by all be detact	by	Part II. Other significant	1 1	ontributing to de	1	_	Inderlying cause gi	ven in Part I.	23e. Did t			the cause of death?
r: The law rec icate has bee r, page 2 sho	Completed	OF Was a second of							1 🗆 Yes	psy ormed?	prior to death?	topsy findings available completion of cause of
is certif directo	To Be	25. Was case referred to examiner?  1  Yes 2  No	-	Hospital:	Inpatient 2	ER/Outpatier	_ Oth	er:  4 Nursing F	ck only one) Home_5 ☐ Resid	dence 6	Other (Spec	ify)
ending Ph sath. or: After th he funeral	Certificate:	2 Accident	Pending Investigation	1	of injury h, Day, Year)	28b. Time of injury	work	y at	28d. Describe h			
intal or Atter de urs after de ral Directo		4  Homicide	☐ Could not b determined	28e. Place buildir	ng, etc. (Specif)	1)	eet, factory, office		City or Tox	n (Street and Number or Rural Route Number, Town, State)		
the Hosp thin 24 ho the Fune mpleted fi	Medical	(Check 2 🔲 I	Medical Exami Certifying Nurs	iner: On the bas	is of examinatio	n and/or inves	death occurred at th	on, death occurred e time, date and pl	at the time, date a	and place, a le cause(s)	and due to the and manner as	cause(s) and manner stated stated.
<b>0.</b> W W.i.		▶ Kam	ru	_CLU!			ROSC ROSC	0603			signed (Monti	
HUA		30. Name and address of Kathryul Ca. 31. Date filed (Month, Da	of person who o	completed caus	e of death (Item	23a) (Type, F	Print) rederic	E, Wdz	1702			
Stat Registra	e ar	o i. Date filed (MOHIII, De	OCT 12	2010	egistar's Signa	ture	A CONS					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 13, 2010 0915 Horst Drever Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** arroll Lutheran Village <u>Health Care</u> Carrol1 Westminster 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country)
Germany Months Days Hours Min. 4/20/1928 **Director** 216-36-0490 82 Usual Residence of Decedent or 28a-f shov notified at show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No PA York Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a or Examiner must be Funeral 165 Panther Dr. 17331 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. ģ 1 Never Married 2 K Married 2 X No Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White "natural", Completed 3 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Machinist Proctor & Gamble Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked of other traumatic ever f and 2 should be if Health and Menta Herman Dreyer Liechen Alexander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14564 Black Ankle Rd., Mt. Airy, MD 21771 Richard Dreyer / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō permit. Page 1 Department of Important: If ii any injury or o 1 🗆 Burial 🖄 Cremation 3 🗆 Removal from State Ardent Cremation Ser. 10/14/2010 4 ☐ Donation 5 ☐ Other (Specify) Hanover, Maryland Signature of Fameral Service Licen 22. Name and Address of Facil Harry H. Witzke's Family FH, Inc. 4112 Old Columbia Pike Ellicott City, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions. Examiner in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 5 Other (specify) should be detached Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 XNo this certificate has page 2 2 No 1 Yes s after death.

I Director: After this certific d in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours a Funeral D Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the pasis of examination and/or investigation, in this opening obtained at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 To the F 29b. Signature and title of certifier

State Registrar Malcolm

M. Let enimoses

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

349

32. Registrar's Signature

PANSURI

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ <sup>Day</sup>4 October 2010 2:25 PMM Gladys Lorraine Borden Diamonte Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cecil E1kton Caraway Manor Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign Country) Elkton Maryland 8. Date of Birth **Funeral** 1 M 2 X F Hours May 19, 1926 Director 84 <u>215-22-8733</u> Usual Residence of Decedent filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No <u>Maryland</u> Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21921 2375 Old Field Point Road 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2XXNo Specify: "natural", 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) ntal Hygiene. ced other than " s event, the Mer Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic eveni 18. Mother's Name (First, Middle, Maiden Surname) Kathleen Mary Hollister Richard Charles Borden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Gina Marie Lane, Elkton, Maryland Oliver A. Diamonte / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date St cematery crematory or other place) Episcopal Cemetery 1 Spurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 19 October 2010 North East, Maryland Crouch Funeral Home 22. Name and Address of Facility 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Hheroscherotic Heart Discase Onset and YEGYS Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine Due to for as a nonsequence of it any leading to immedia cause. Enter Underlying Cause (Disease or iinjury that initiated events the attending physician and thed for use as the burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year 1 L Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? D'abdes Mellitus Cype II 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2. performed' 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20023322 Jackden8110 10.15.2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. S Sachder MD R6 A E High St Elpton MD 21921

State Registrar

3. Time of Death

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

2 🗌 No

Year

1 X Yes 2 No

1708 PM

DHMH 17 Rev 7/2009

State Registrar MD

32. Regist

Freedman

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 6 2010 2010 6:30 A Jeremiah Joseph Driscol1 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, March 27 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Country)
Washington. 1XXM 2 578-40-1736 85 March Director Usual Residence of Decedent or 28a-f show 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene.
Important: If item 27 is marked other than "nortant any injury or other tween-10c. City, Town or Location 10a. State **Funeral Director** 1 Yes 2 XNo Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3660 6th Avenue 21037 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. ģ 1 Never Married 2 Married 1 X XYes 2 🗌 No 1 ☐ Yes 2x No Specify. Specify: White Completed XX Widowed 4 Divorced Year or Dates. WW II 16b. Kind of Business Industry 15 Decedent's Education 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 10th College (1-4 or 5+) Carpenter D.C. Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Jeremiah Joseph Driscoll Sr. Helen Margaret Stansburv 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kathleen Driscoll Williams / Daughter 702 Fantail Court Annapolis, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 10/12/2010 Resurrection Cem. Clinton, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 21. Signature Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme late Cause (Final 13100d DYSCARIASIS Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Completed by Physician/Medical EMENTIA Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Dav Yea Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No Yes 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: ဂ္ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) title of certifier 29c. License number 29b. Signature at HOSPITALIST 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Amee Desai MD Jennifer Road Annapolis, Maryland 21401 Amee Desai

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10/772010 Dorothy Mary Doswell  $A^{\mathsf{M}}$ 7:40 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Prince George's Hospital Cheverly Prince George's 7. Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🔀 F Days (Month, Day, Year) 9/20/1922 Hours Min. Washington, Director Yrs 577-28-4349 88 Usual Residence of Decedent 28a-f shov 10a. State 10h County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director Examiner must be notified MD Prince George's 1 X Yes 2 No Bladensburg 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral with 5310 Tilden Road 20710 USA items death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. "natural", or 1 Never Married 2 X Married þ 1 ☐ Yes 2 🕱 No If Yes, Give Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the 12 Homemaker Own Home Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o marked ပ pe Benjamin Burnett Margaret N. Burkley Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health James T. Doswell / Husband 5310 Tilden Road, Bladensburg, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 10/14/10 Brentwood, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, PA Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of): disease or condition Medical resulting in death) Examiner WKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner NFECTIONS, PEG TUBE burial-transit WKS Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No jo 5 Other (specify) Day Month Year Pregnant at time of death detached the Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? þ should be MELL 17 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform BRILL certificate 4) ATRIAL 1 ☐ Yes 2 ☐ No Yes 2 No Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 🗆 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury s after death.

I Director, After the in by the funera 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural (Month, Day, Year) 5 Pending 2 Acciue 3 Suicide 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined To the Hospital or within 24 hours at To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 021428 reenn

Registrar

DHMH 17 Rev 7/2009

State

3001 Hospital Drive, Cheverly, Maryland 20785

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar Signatu

Linda Green,

OCT 1 2 2010

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 2010 10:25 p.M. Felicia Edens October Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/22/1950 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthdav) Social Security Number Funeral Days Min. 1 □ M 2 🗓 F Hours Director 216-58-2961 60 Usual Residence of Decedent and Mental Hygiene. is mar ed other than "natural", or items 23a or 28a-f show aumati. event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No California Maryland St. Mary's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Unite States 44847 Shady Hollow Lane 20619 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces? 1 ☐ Yes 2 XNo If Yes, specify Cuban, Mexican, Puerto Rican, etc." Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 🖾 No Specify: If Yes, Give 3 - Widowed 4 - Divorced Completed Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Education Paraeducator Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should ue f Department of Health and Menta Important. If item 27 is mar ed any injury or other traumati ev ဨ Theresa Mary Aglialaro Joseph Manca 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 44847 Shady Hollow Lane, California, MD Robert E. Edens, Jr./Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 12/08/2010 Arlington, Virginia lington National Signature Floring September 1988. Edward N. Brinsfield, 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M00052 22955 Hollywood Road, Leonardtown, MD Jr. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) MINS Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death Day Year signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ ac/UMP 1 Yes 2 No 3 Probably 4 Known Completed 24b. Were autopsy findings available prior to completion of cause of has autopsy performed Yes 2 death? 2 NO 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Datural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the vest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the Within 2 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) 16/2010 30. Name and address of person who completed leted cause of death (Item 23a) (Type Print) (en

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day ames w. 5:55 PM octoper 201D Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fahrnei Boonsboro Washin If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Date of Day (Month, Day 20 1 🗷 M 2 🗆 F Months Hours Min 217-26-9645 90 Director Ohio Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director W. Va. Jefferson Harpers Ferry 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 298 Union Street 25424 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1 Nes 2 No 1942-Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 White If Yes Give 1 ☐ Yes 2 X No Specify. 1947 Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ge 1 and 2 should be filed within 7, tt of Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) 12 4 Ordnance Engineer U. S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Davis Babb Elam Nettie Wheeler Mae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert D. Elam / Son 14656 Peddicord Road, Mt. Airy, Md. Baltimore, 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) All Souls Cemetery 10/14/10 Germantown, Maryland Signature of Funeral Service Licenses Name and Address of Facility
Muriel H. Barber Funeral Home 0. Box 5038, Laytonsville. 20882 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee On, et and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner pertension Esquentially not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Mellitus Hospital or Attending Physician: The law requires that the death certificate be executed abetes signed by the attending physician and defached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Dav Year Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy perform death? 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work? 2 No Accident Investigation within 24 hours after death To the Funeral Director. Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Yeate M. Smoth R128088 October 11,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kate M. Smith, CRNP 1126 Opal Court, Hagerstown, Md. 21740 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT CENTRAL Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 9, 2010 Rosemary Edwards 5:00

4b. City, Town, or Location of Death

Laurel If Under 1 Year If Under 24 Hrs.

20720

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Hours

Days

Months

10f. Zip Code

16a Decedent's Usual Occupation

Painter

1 ☐ Yes 2 X No Specify.

(Give kind of work done during most of working life. DO NOT use retired)

7. Age (In yrs. last birthday,

10c. City, Town or Location

Bowie

52

12. Was Decedent Ever in U.S.

☐ Yes 2 🔀 No Yes, Give

Armed Force

Year or Dates

College (1-4 or 5+)

4c. County of Death

10g. Citizen of What Country?

14. Race - American Indian,

Rucker Contractors

White

Black, White, etc.

USA

Specify:

16b. Kind of Business Industry

8. Date of Birth

18. Mother's Name (First, Middle, Maiden Surname)

Emily Huston

8616 Maple Avenue, Bowie, MD 20720

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

(Month, Day, Year) March 16, 1958

Prince George's

9. Birthplace (State or Foreign

10d. Inside City Limits

1 X Yes 2 No

Cheverly, MD

Physician/ Medical Examiner State Registrar

10a. State

Maryland

11. Marital Status

10e, Street and Number

Director

Funera

à

Completed

218-68-3765 Usual Residence of Decedent

8616 Maple Avenue

1 Never Married 2 Married

3 Divorced 4 Divorced

Elementary/Seconday (0-12)

17. Father's Name (First, Middle, Last)

Robert Lee Ramsey

19a. Informant's Name/Relationship (Type, Print)

James M. Edwards / Son

10

4a. Facility Name (if not institution, give street and number)

Cherry Lane Nursing Home

1 M 2 X

Prince George's

15. Decedent's Education

(Specify only highest grade completed)

**Funeral** Director

shov with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death unent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items other traumatic event. injury or permit. Page Department of Important: If any injury or once,

Baltimore, Maryland 21215-0036

Physician/ Medical Examiner

resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir burial-transi Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Pregnant at time of death 1 Yes 2 After this certificate has been signed by the funeral director, page 2 should be detached Unknown \$ Division of Vital Records, Completed 25. Was case referred to medical examiner? Be Hospital: 1  $\square$  Yes ᅆ Director: After this 27. Manner of Dea 28a. Date of injury 28b. Time of Certificate: (Month, Day, Year) Natural injury 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be filled in by determined 24 hours a Medical 29a. Certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14333

OCT 1 2 2010

20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 10/11/2010 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue RAY Rogers Gasch's Funeral Home, PA Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset an Death Immediate Cause (Final disease or condition 23d. Date of delivery 3 Ectopic pregnancy Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 No 26. Place of Death (Check only one) Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at 28d. Describe how injury occurred work?
1 Yes M 2 🗌 No Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) Th 24721 2010

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Joy 20x011:10 PM Eldridge Louise 400 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 9. Birthplace (State or Foreign Country) West Virginia havenwoo otheran Village If Under 1 Year Munder 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. (Month, Day, Year)

April 17,1922 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Sex 1 □ M 2 KF 88 Director 219-12-0485 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-1 shov ury or other traumatic event, If a Medical Exandia to Inust be notified at 1 ☐ Yes 2 X No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20402 Kings Crest Blvd. 21742 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 X Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bread/Milk Distributor Bookkeeper/Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ Arthur Jackson Michael Chlorus Ann Fearnow 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other troone. Julie E. Carbaugh 12720 Spickler Road, Clear Spring, Maryland 21722 Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery 10-25-10 |Hagerstown, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Andrew K. Coffman Funeral Home, Inc.
40 East Antietam Street, Hagerstown, 21. Signature of Funeral Service Licensee hoel Brade 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician umour month disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlar-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death in the past 12 months? 3 🗀 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an performe 1 ☐ Yes 2 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DDA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Natural
Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Momicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10/2/110 Menten

Registrar DHMH 17 Rev 1/2001

State

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Hagreten 19021740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAP

32. Registra

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mary Catherine Forkin a.k.a. Jean Louise Forkin October 5 2010 3:51 p Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Sept. 3, 19 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 X F Director 72 350-86-8159 Ohio Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f ehror any injury or other traumatic event, the Medical Examples. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 628 Bay Ridge Avenue 21403 HSA Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 🔀 No 1 ☐ Yes 2x No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Health Care Administration Religious Sister of the Holy Cross Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Aloysius Forkin Mary Louise Sherlock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Sinclair, CSC/Religious Supervisor 13620 Jacqueline Court, Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Gate of Heaven Cemetery Oct 11, 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins 500 University Blvd. DN K Funeral Home Inc. W., Silver Spring, 10 CM9A MD 20901 23a. Part Y. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) (or as a nsequence of Examiner Sequentially list conditions, Examine If any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence oi). g physician and as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 Yes 2 No Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 Yes Hospital 2 No မ 1 Nopatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner To the best of my knowledge, do at the time, data and plane, and due to the nause(s) and manner as stated 29b. Signature and title of certified 29c. License number 29d. Date signed (Month. Day. Year) MD

Registrar DHMH 17 Rev 7/2009

State

30. Name and address of per

31. Date filed (Month, Day, Year)

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who completed cause of death (Item 23a) (Type, Print) 2001

Registrar's Signatu

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State Registrar 32. Registrar's Signature

			For State Registrar	State of I	Marylan		artmen <i>tificate</i>			Mental Hy	giene Reg. N	201	Λ	33	719
			Decedent's Name (First, Middle, L	_ast)				-		2. Date of D	eath			3. Time o	f Death
	Physicia Media		Leonard Benedic	t Farrell						October	D:	ау .6	Year 2010	1:45	АМ
	Examir		4a. Facility Name (if not institution, g		7)		4b. City,		ocation of Dea		40	c. County o			
			St. Mary's Hospi						ardtow			St.	Mary		
	Funeral Director		213-38-2936	1 K M 2 🗆 F	Age (In yrs. Ia	88 Yrs.	If Under Months		If Under 24 Hi Hours Mi		rth a <i>y, Year)</i> 0 <b>, 1</b> 9	22	Count	ace (State ory) y <b>lan</b> d	or Foreign
	nd now at	اۃِ ا	Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Loc	cation						10	Od. Inside C	ity Limits
	arylar a-fsl	ect	Maryland St. Ma	arv's			Compt	on							s 2 🗆 🗙 o
	or 28	[吉	10e. Street and Number				10f. Zip				10g. C	itizen of W	hat Count	ry?	-
	with s 23a ust b	Funeral Director	22354 Bayside Ro	ad				2	0627			USA			
980	e filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status  1 ☐ Never Married 2★ Marrie  3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Force d 1  Yes 2 If Yes, Give Year or Dates	S? K No	l II	Vas Deced Yes, spec	ify Cuban,	Mexican, Pue	Specify Yes or No rto Rican, etc.)	-	14. Race Black Specify:	, White, e	tc.	
Baltimore, Maryland 21215-0036	ithin 72 hour ene. r than "natu the Medical	Completed by	15. Decedent's (Specify only highest Elementary/Seconday (0-12)			16a. Deced (Give A life. Do	kind of wor D NOT use	k done du	ion ring most of w	orking	Uni	Kind of Bus ted St ernmen	ates	ustry	
<b>d</b> 2	filed w al Hygi d other	船	17. Father's Name (First, Middle, Las	it)		ourpen		1	18. Mother's N	ame (First, Middle	, Maider	Surname)			
<u>ılan</u>	ould be fill and Mental marked amatic even	잍	William Joseph F	arrell, S	r.				Edith 1	Mabel Bu	ss1e	r			
lan	ar is		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address	(Street an	d Number or F	Rural Route Numb	er, City o	or Town, Sta	ate, Zip C	ode)	
≥,	ind 2 ind 2 ind 27 ind 27		Mary Elizabeth Farre	ell/ Wife		1			ide Road	Compton,			0627		
more	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other		20a. Method of Disposition  1 □ kBurial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spe		ate Saci	lace of Dispo emetery, cren red Hear	sition (Nan natory or o 't	ne of ther place)	0ct 2010	Date ober 21,		Location - (	,		
alti	permit. F Departm Importal any injul		21. Signature of Funeral Service Lic	enspé //	•	etery 22	. Name an	d Address		attingley-					P.A.
<u>m</u>	e E E E		Michaelt	Lander	ier					O. Box 270					
	Physician/		23a. Part I. Enter the disease, or or show, or heart failure. List onl Immediate Cause (Final disease or condition	ompli tions that caus y one cause on each	line.	n. Do not ente			such as cardi	ac or respiratory a	rrest,			Approxima Interval Be Onset and	tween
	Medical Examiner		resulting in death)	a. Due to (or a	as a consequ	ience of):			19-25					_	
		e	Sequentially list conditions,	b. Fuetcher	71CL	ITE M							-		
	ted    -   nsit	Examiner	if any, leading to inmediate cause. Enter Underlying Cause (Disease or iinjury	245 (6)	CAD	150	VEMIC	CACI	DICKYSPA	714/					
	ate be executed physician and the burial-transit	E E	that initiated events resulting in death) Last	C. Due to (or a	as a consequ	ience of):			/	/					
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Division of Vital Records, P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeal Director After this certificate has been signed by the attending I for the Funeal Director. After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown	23c. If yes, outcon 1  Live Birt 4  Pregnan 9  Unknow	h 2 ☐ Feta t at time of d	l death 3	Ectopic p Other (sp				Ì	23d. Date Mon			Year
P.0	that t ned b e deta	by P	Part II. Other significant conditions	s contributing to deat	h but not resi	ulting in the u	nderlying o	cause give	n in Part I.	23e. Did	tobacco	use contrib	oute to the	e cause of o	death?
ds,	quires en sig ould b	ted								_ 1 🗆	Yes 2	2∃No 3	3 🗌 Prob	ably 4 🗌	Unknown
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tal	cian: ertific ector,	Be	25. Was case referred to medical examiner?	Hospital:				Lau	e of Death (Ch	neck only one)					
τŞ	Physi this c	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 Inp		ER/Outpatien		Other: 8c. Injury a	4 L Nursing	Home 5 Res					
n o	d <b>ing</b> th. After funer	cate	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigat	(Month, I	Day, Year)	injury	M	work?	at es 2 □ No	28d. Describe	now inju	iry occurred	1		
Divisio	ial or Atten s after dear al Director: ed in by the	l Certificate:	3 Suicide 6 Could no 4 Homicide determine	t be 28e. Place of	Injury - At ho etc. (Specify,	me, farm, stre				28f. Location City or To			or Rural	Route Num	ber,
	Hospi 24 hour Funera ited fills	Medical	(Check 2 Medical Exa	hysician: To the best aminer: On the basis of	f examination	and/or invest	igation, in	my opinion	death occurre	d at the time, date	and plac	e, and due	to the cau	se(s) and m	anner stated
	o the vithin 2 o the omple	ž	only one) 3 Certifying N 29b. Signature and title of certifier	urse Practioner: To t	he best of my	/ knowledge, c		red at the t . License r		olace, and due to t		(s) and man ate signed			
0	# \$ F ö			in MA											
100	me		30. Name and address of person wh	o completed cause o	f death (Item	23a) (Type, P	rint) 3 5	500	Point	200100	+ Re	ad.			
J P			31. Date filed (Month, Day, Year)  OCT 182	MALINI	trar's Signat	WAY APZI	TOLUL	i i	10 206	50					
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			_ For	State of Maryland					lental Hyg	iene			
			State Registrar		Cer	tificate o	of Dea	ath	R	eg. No.2	33720		
	Physicia	n/	1. Decedent's Name (First, Middle, Last)						<ol><li>Date of Deat Month</li></ol>	h Day Year	3. Time of Death		
	Medic	al	Barbara S.	Fertich					<u>October</u>	10 2010	5:50 P <sup>M</sup>		
	Examin	er	4a. Facility Name (if not institution, give str			,,		cation of Death		4c. County of Dea			
المحمودة	Francis		Citizens Care and 5. Social Security Number 6. Sex			Fred If Under 1	leric Year   If l	K Under 24 Hrs.	8. Date of Birth	g. Bir	erick thplace (State or Foreign		
	Funeral Director			M 2 🖾 F 95	Yrs.	Months D	ays H	ours Min.	(Month, Day, August	<sup>Year)</sup> 26,1915 Pe	untry) nnsylvania		
	ě		Usual Residence of Decedent										
	yland f sho ed at	햣	10a. State 10b. County		Town or Loc	ation					10d. Inside City Limits 1 🏝 Yes 2 □ No		
	Mar 28a- notifiu	.= 1	Maryland Frederic	ck	Frede	rick 10f.Zip Co	-1-			10g. Citizen of What Co			
	th the	<u>  a</u>	10e. Street and Number		,	Tor. Zip Go		2					
	ath w	Funeral	1709 W. Seventh S	treet Apt. T-  2. Was Decedent Ever in U.S.	13. V	Vas Decedent	2170	nic Origin? (Spe	cifv Yes or No-	United 14. Race - Ame			
(C)	within 72 hours after death with the Maryland giene. ier than "natural", or items 23a or 28a-f sho ; the Medical Examiner must be notified at		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 K No	"	Yes, specify	Cuban, M	lexican, Puerto	Rican, etc.)	Black, Whit	e, etc.		
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5-0	"natu	plet	15. Decedent's Edu (Specify only highest grade			ent's Usual O		n ng most of worki	ng	16b. Kind of Business	Industry		
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,	d wit	Be C	17. Father's Name (First, Middle, Last)		Sean	stress		Mother's Name	First Middle M	Maiden Surname)	nufacturing		
and	be filed yental Hygrked other	일	Nicholas Lubitich				- 1		Bresnal				
Maryland 21215-0036	should be file n and Mental I <b>7 is marked c</b> raumatic eve		19a. Informant's Name/Relationship (Type		19b. Mailin	a Address (S				City or Town, State, Zi	p Code) 21702		
	12 shalth an 27 is		Barbara Mann / Dau	ghter	1709	W. Sev	renth	Street	, T-4	Frederick,	-2.02		
altimore,	of Heal of Heal of item ?		20a. Method of Disposition	20b. Pla	ace of Dispo	sition (Name on atory or other	of er place)	r	Date	20c. Location - City of	Town, State		
Ĕ	Page 1 nent of ant: If it ury or o	П	1 ☐ Burial 2 🖾 Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	terrioval ironi State		Crema		10-13	-2010	Allentown,	Pennsylvania		
ä	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Sign are of Funeral Service Licensee	. 1	22	. Name and A	Address of	f Facility Sta	uffer F	uneral Hom	es, P.A.		
<u> </u>	포크트웨리	Ш	Sonaron Gan	ulle Glu							ryland 21702		
			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one	cations that caused the death. cause in each line	. Do not ente	0					Approximate Interval Between Onset and Death		
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×	aath certifica attending p I for use as 1	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnan 1  Live Birth 2  Fetal 4  Pregnant at time of de	death 3	Ectopic pre				23d. Date of de Month	elivery Day Year		
ă	e dea the a	Physician/Me	1 ☐ Yes 2 No 9 ☐ Unknown	9 Unknown	eau o L		y)						
Ö.	requires that the de been signed by the should be detached		Part II. Other significant conditions con	tributing to death but not resu	Iting in the u	nderlying cau	use given i	in Part I.	23e. Did to	bacco use contribute t	o the cause of death?		
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Ξ	hysic his ce il dire	2	1 🗆 Yes 2 No	ospital:				_		ence 6 Other (Spe	cify)		
ַסָּר	ling P	Certificate:	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury		. Injury at work?	s 2 □ No	28d. Describe h	ow injury occurred			
sior	death death ctor: /	ţį	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hon	ne. farm. str	M eet. factory. o		S Z LINO	28f. Location (S	treet and Number or R	ural Route Number,		
Division of Vital Records, P.O. Box	after after Direct		4 Homicide determined	building, etc. (Specify)		,		ļ	City or Tow				
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physic	cian: To the best of my knowle er: On the basis of examination	edge, death	occured at the	e time, da	ite and place, an	d due to the cau	ise(s) and manner as s	tated.		
	the Ho nin 24 the Fu	Me	only one) 3 Dermying Nurse	Practioner: To the best of my	knowledge,	death occurred	d at the tin	ne, date and plac	e, and due to the	cause(s) and manner a	s stated.		
_	So wit		29b. Signature and title of certifier	La Shorin	1	29c. L	icense nu	-/397	,	29d. Date signed (Mon	ui, Day, rear)		
			an Name and Indiana	imploted cares of death (14-	230) (5000 5	Print)		. 3/1	/	10/11/	10		
	4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Robert L. Kaufmann, M.D. 300 W. Ninth Street, Frederck, Maryland										
	Sta	te	31. Date filed (Month, Day-Year)	32. Registrar's Signatu		,							
	Registr	ar	4. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	20 Denerous	, B.	San March	Manager						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State 33721 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Year **EDWARD** 2010 FLETCHER OCTOBER JR Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SOUTHERN MARYLAND HOSPITAL PRINCE GEORE'S CLINTON 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Months (Month, Day, Year) 1 ▼ M 2 □ F 89 Days Hours Director MARYLAND 219-10-3103 IULY 6. Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 X Yes 2 No MD PRINCE GEORGE'S DISTRICT HEIGHTS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1430 SHADY GLEN DRIVE 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian was becedent Ever in U.S.
Armed Forces?
1 ▼Yes 2 □ No ARMY
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify BLACK Completed 3 Divorced 4 Divorced Specify: er than "natur , the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the N 12TH PATTEN ISSUE OFFICER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည EDWARD M. FLETCHER SR. BESSIE MATTHEWS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20747 VIRGINIA D. FLETCHER/WIFE 1430 SHADY GLEN DRIVE DISTRICT HEIGHTS, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 😾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) HARMONY CEMETERY 10-12-2010 LANDOVER, MARYLAND Sun ture of Dineral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician DOXIC Unknown Medical resulting in death) Due to or as a consequence of Examiner vascular Unknown Sequentially list conditions, Physician/Medical Examiner if any, leading to infried ate cause. Enter Underlying Cause (Disease or linjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and use as the burial-trai Due to (or as a consequence of) attending physician for use as the burial Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant g Unknown 5 Other (specify) Month Day Year Pregnant at time of death signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 V Unknown been : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page 2 To the Funeral Director: After this certificate completed filled in by the funeral director, pag 1 ☐ Yes 2 🕅 No Yes 2 X N 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: 2 🛛 No 1 🗌 Yes Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 X Natural 5 Pending ☐ Accident Investigation 24 hours after death Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year)

State Registrar 1143446

12150 Annapolis Read Suit 312 Glen dale, MO 20769

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M.D

Rointa Fantofor

FARAHIFAR

31. Date filed (Month, Day, Year)

2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

32. Resistrar's

Baltimore, Maryland 21215-0036

		1 - For State Registrar	State of Maryla		ertificate of i			eg. 12. 0   0	33722
DI		1. Decedent's Name (First, Middle, Las	st)				2. Date of Deat Month		3. Time of Death
Physici /Medi		Josephine	Purcell Gi	cennan			Oct.	9, 2010	9:30 p.M
Examir		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or	Location of Death	1	4c. County of Deat	h
o—		Carriage Hill Be	ethesda	1 11:41		esda	Tab. (810)	Montgome	
Funeral		5. Social Security Number 6. S	OF Age (In yrs	s. <i>last birthda</i> y Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	, Year) Co	hplace (State or Foreign untry)
Director		559-22-4757 Usual Residence of Decedent	100	110.			Sept.28	, 1910 I1	linois
rland ow at		10a. State 10b. County	10c. C	ity, Town or L	_ocation	74701			10d. Inside City Limits
Man Fish fied	to	D.C. None		Washin	gton				1. Yes 2 □ No
h the	ired	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	untry?
th wit	Funeral Director	5101 Watson St.	N.W.		20016			U.S.A	
ems ems	iner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13	. Was Decedent of H	ispanic Origin? (S	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White	rican Indian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify:			White
72 h 'natu dical	Completed	15. Decedent's Ed (Specify only highest gra	lucation ide completed)	ı (Giv	edent's Usual Occup	durina most of wor	king	16b. Kind of Business/	Industry
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iled w Hygie <b>her ti</b> nt, th	ខ	17. Father's Name (First, Middle, Last)	4		Homemal		ne (First, Middle, I	Own Home	
t be f intal h ed of	Be						•	vialueir Surriairie)	
hould Me mark	은	Albert Purcell  19a. Informant's Name/Relationship (	Type Print)	19h Mai	ling Address (Street	Mary Nary Number or Bu		r, City or Town, State, 2	Zin Code)
id 2 s Ith an 27 is trau		Juliet G. Ronhov	•	4911	Jamestow	n Court		, only or rown, chare, 2	sp oode)
s 1 ar f Hea tem 2		20a. Method of Disposition		Place of Disc	esda, Mar position (Name of		20816 Date	20c. Location - City or	Town, State
Pages ent of nt: If i		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐			ematory or other place ofitan	0ct.	$\frac{11}{10}$ ,	A 7 1	77.
artmoortar		21. Signature of Funeral Service Licer		Cremat	22. Name and Addre			Alexandria, eral Home	Virginia
permi Depa Impo any ir		Henry Lite	√ M0021.	5 2	222 Wiscon			shington,	D.C. 20007
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de-	ath. Do not e	nter the mode of dyir	g, such as cardiad	or respiratory arre	est,	Approximate Interval Between
Physician	1.7	Immediate Cause (Final disease or condition		F 74 B	WILA				Onset and Death
/Medical		resulting in death)	a. Due to (or as a conse		, , , ,				
Examiner		Sequentially list conditions	b						
10 H	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	equence of):					
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ding se as		IF FEMALE:	23c. If yes, outcome pf preg	nancy				201 5.1(11	
To the Hospital or Attending Physician: The law requires that the death certificate be exeminated within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of del Month	Day Year
that ned by deta		Part II. Other significant conditions of	ontributing to death but not re	sulting in the	underlying cause give	en in Part I.	23e. Did tob	bacco use contribute to	the cause of death?
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s bee	Completed						24a. Was a		utopsy findings available
Fhe lav te has age 2 :	ЩC						autops	med2 death?	completion of cause of
an: Tiffica tor, p	Be	25. Was case referred to medical				26. Place of Dea	th (Check only on		2,164110
Physician: The lant this certificate had irector, page 2	0	examiner? 1 ☐ Yes 2[\$#No	Hospital: 1 ☐ Inpatient 2[	☐ ER/Outpatie	ent 3 DOA Oth	or:		ence 6 □Other (Spe	cify)
ding Ph  After th funeral	n: T	27. Manner of Death 1 Manual 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury		y at		ow injury occurred	
endir ath. or: Al	atic	2 Accident investigation		1 , ,		Yes 2 □ No			
or Attendater death Director: in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At building, etc. (Spec	home, farm, s	street, factory, office		28f. Location (St City or Town	treet and Number or Ru n, State)	ıral Route Number,
ital cars af		1-6							
To the Hospital or Attending Is within 24 hours after death. To the Funeral Director: After Completely filled in by the funer.	Medical	29a. Certifier 1/2 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my ki niner: On the basis of examil and manner stated.	nowledge, dea nation and/or	investigation, in my c	pinion, death occu	e, and due to the curred at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
Not To To To To To To To To To To To To To	2	29b. Signature and title of certifier	MSeo, U	91	29c. Licens	number	1	9d. Date signed (Mont	
6		<u> </u>				3 / 1	7	10/11	110
		30. Name and address of person who	10110 Ma	JE CUL.	AR DONE	Rocki	TILLE, M	D 20850	
Sta Registi		31. Date filed (Month, Day, Year)  OCT 12 201	3). Registrar's Sign	1. 4a	whole.				

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State RegistrAMEND#10e, fperINF, 10/18/10, bww, McoCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Norman Greenberg 2:20 A.M 2010 October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Arcola Health and Rehabilitation Center Silver Spring Montgomery 5. Social Security Number 8. Date of Birth (Month, Day, Y April 29 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral Days Hours 1 🔀 M 2 🗆 F 1927 Pennsylvania Director 83 200-20-6149 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 X Yes 2 ☐ No 10e Street and Number 1220 East West Highway #420 2146 Georgian Woods Place 10g. Citizen of What Country? <sup>10</sup>20910 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 ☐ No If Yes, Give 1945—1946 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify: Specify:White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Public Information Officer U.S. Government 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Jacob Greenberg Lillian Wilner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Keith Greenberg/Son 708 Easley Street, Silver Spring, MD 20910 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Geo. Wash. University Medical Center 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 4 🔀 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Columbia Mortuary Services, P.A. 21. Signature of Funeral Service Licer /M00969 9013 annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death ALZHEINER'S Physician/ Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? ō Pregnant at time of death Month Dav Year rate has been signed by the page 2 should be detached 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No Yes 2 N within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann f Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of prtifier 108834 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROSEMBAUM 3720 FARRAGUT AUG KENSINGYON

Registrar

State

Date filed (Month, Day,

Year

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

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0	Examin	er	4a. Facility Name (ii Shady Gro	ove Adv	enti	st Hos	spita]			Roc	, Town, or k <b>vi</b> l	le				4c. County iontgo	omery		
	Funeral Director		5. Social Security N 484-32-34 Usual Residence of	468	6. Sex	12 <b>X</b> F	7. Age (In yr <b>84</b>	s. last birthda Yrs	΄ Γ	If Und Months	er 1 Year Days	If Under Hours	Min.	8. Date of (Month)	Birth Day Year 2/192	6	9. Birth Cour <b>Ge</b> r	place (St ntry) <b>many</b>	ate or Foreign
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68760	icate be physic s the b	ledic			d. ,														
Box 68	<b>Physician:</b> The law requires that the death certificate be this certificate has been signed by the attending physicial director, page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 9 ☐ Unknowr	months? No	23c.		Birth 2 🗆 F ant at time	etal death		Ectopic Other (s		ру -				i .	ate of deliv	ery Day	Year
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Vita	ysician: is certific director,	To Be	examiner?	X <sup>'</sup> No	Hos	pital:	npatient 2	☐ ER/Outpa	tient	з 🗆 г	Oth	ace of Dea er: 4 🗌 N		me _5 $\square$ R	esidence	6 □ Oth	ner (Specif	)	
اه ر	ding Ph J. After th funeral		27. Manner of Deat 1 Natural	5 🗆 Pendii	ng	28a. Date o (Month	of injury in, Day, Year)	28b. Time injur		М	28c. Injury work	y at ? Yes 2	_	28d. Describ	e how inj	ury occurr	red		
Division	to the Hospital or Attending Phyithin 24 hours after death.  To the Funeral Director: After this completed filled in by the funeral	Certificate:	2 Accident 3 Suicide 4 Homicide	Investi 6	not be		of Injury - At g, etc. (Spe	t home, farm, cify)	stree			165 21		28f. Locatio City or	n <i>(Str</i> eet a Town, Sta	and Numb	er or Rura	l Route l	lumber,
	Hospital 24 hours 3 Funeral I leted filled	Medical	(Check 2	Certifying	xaminer:	On the basis	s of examina	ation and/or in	estig	gation, ir	n my opinio	on, death o	ccurred at	the time, da	te and pla	ce, and du	ie to the ca	use(s) an	d manner state
	within 2 To the To the omple	Σ	only one) 3 29b. Signature and	title of certifie						29	c. License	e number			29d. [	Date signe	ed (Month,	Day, Yea	
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			30. Name and add	L MUR	RAY	mD	9901	<b>か</b> tem 23a) (Type <b>M</b> を <b>D</b> 1と	e, Prin	nt) . CE	NTER	DRI	VE 1	ROCKU	ILLE	MAR	RYCA	MD	20850
	Sta Registra		31. Date filed (Moni	th, Day, Year)	2010	3. Re	gistrar's Sig	nature de	w	در	a								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Charle of Manyland / Department of Health and Mental Hygiene 2010 33725

		n- For State Registrar			Certiff	cate of L	Jeath 			teg. No.		
Physici	an/	1. Decedent's Name (First, Midd	e,Last)						Date of Dea     Month		Year	3. Time of Death
ledical Exami	ner	David Troy Ga	lbrait	h					October 8	B, 2010	ı vai	1559 hrs
		4a. Facility Name (if not institution				4b.	. City, Town, or Lo	ocation of Deatl	1	4c. Coun	nty of Death	1
		1413 # B 1 Key Parkv		,			Frederick			Frede	rick	
		5. Social Security Number	6. Sex	7 Δαρ	(In yrs. last b		If Under 1 Year	If Under 24Hr	8 Date of Ri	rth (MM/DD/YY	YYY 9. Birt	thplace (State or
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Director		215-08-8198	1XM 2	F	¥1	Yrs.				17,196	9 Cou	<sup>untry</sup> Washingto:
	į	Usual Residence of Decedent							153			
any		10a. State 10b. County		T	10c. City, Tov	vn or Location	1					10d. Inside City Limits
rg Ke	اے	Marriland Ex	ederic	1.	Myers	111 1 1 a						1 Yes 2 No
daryland 28a-f show 1.at once.	용	Maryland Fr 10e. Street and Number	edelic	Λ.	Hyers		10f, Zip Code		· ·	10a. Citizen of	What Cour	ntry?
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Director						,,					
h the 3a o		10088 Vista Co	urt				2177	<del> </del>			ed Sta	ates
wit ms 2	Funeral	11. Marital Status		as Decedent I	Ever in U.S.		Decedent of Hispa , specify Cuban, I				ace - Ameri hite, etc.	can Indian, Black,
death r ite	S	1 X Never Married 2 M	arried 1	-	X No	11163	, specify Cubari, i	Wexicall, Fuelt	/ (Clour, etc.)	"	riite, etc.	
fter l", o		3 Widowed 4 Div	orced If Yes, G	Sive Year		1 Y	es 2X No	specify:		Specia	fy: Wh:	ite
hours after "natural", Examiner	d b	15, Decedent's Education (Spe			oleted) 16		Usual Occupatio			16b. Kind of		
2 ho "na	Completed	Elementary/Secondary (0-12)	Co	llege (1-4 or 5	+)	during mos	t of working life. [	O NOT use ref	ired)			
36 hin 73 e. than edical	ᆲ					14	1					
With With	팅	12 17. Father's Name (First, Middle	Loct)			Me	echanic	Mother's Name	e (First, Middle,		omoti	ve
Hyy H											ilic)	:
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	B	Walter J. Galb							illiams			
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-1 sh matic event, the Medical Examiner must be notified at once	2	19a. Informant's Name/Relations				_	Address (Street a					
MD d 2 shc lth and n 27 is		Walter J. Galb	raith/	Father			Vista Co		ersvill	e, Mar	yland	21773
Heal Heal		20a. Method of Disposition					on (Name of ceme	etery,	Date	20c. Location	on - City or	Town, State
nore, MD 21215-0036 spes I and 2 should be filed within 72 nt of Health and Mental Hygiene. t: If item 27 is marked other than ' other traumatic event, the Medical		1 Burial 2 X Cremation		noval from Sta		atory or other		-	/11/001	L .	. 1	16 1
timen trant		4 Donation 5 Other S			Stau						erick	,Maryland
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thingury or other traumatic event, the Med		21. Signal of Funeral Service	Licensee	man	1		ne and Address o					
ш адыя	11/1/	-10dll X	1100	YWY			-					yland 21702
Physician		2 art I. Enter the disease, or failure. List only one cause					mode of dying, sa	uch as cardiac	or respiratory ar	rest, shock, or	heart	Approximate Interval Between Onset and
/Medical		Immediate Cause (Final disease	Colo		le thado <del>lydroc</del> o	odone	and alpr	azolam	intoxic	ation		Death
Examiner		or condition resulting in death)	-	or as a conse								
			b		,							
	ᡖ	Sequentially list conditions, if any, leading to immediate	Due to (	or as a conse	quence of):							
	Examiner	cause. Enter Underlying Cause	C.									
	ᡖ	(Disease or injury that initiated events resulting in death) Last	Due to (	or as a conse	quence of):							
xecuted n and - transit			d.									
exec an ar al - ti	<u>8</u>	X UNPENDED	X AMEN	<sub>vDEQ</sub> #23a	,ptI,per	ME,G910	,12/21/10, g910 12	WS				
1760, ficate be execute g physician and the burial - tran	n/Medical						g910 12	/7/10 T	<u>'T</u>	1 22 4 D-4-	of deliver	ļ
8760, tificate be ng physic as the bur	ا≩ا	IF FEMALE: 23b. Was decedent pregnant in t		If yes, outcom	e or pregnanc		doath 3	Ectopic pregn	ancv	Month	of delivery	y Day Year
certi certi ndin	흥	past 12 months?	4	_	ime of death	2 Fetal	(Specify)	_Lotopio progri	unioy	Mona		
Box 61 ne death cert the attendir	ું છું	1 Yes 2 No 9 Un	known g	Unknown		J □ Otne	(Specify)					
the d	Physicia	Part II. Other significant condi			but not result	ting in the unc	derlying cause giv	en in Part I	23e. Did 1	obacco use co	ontribute to	the cause of death?
P.O. es that the igned by	ā	,		amig to accum	2411011004	g a.io a.i.	sorrying cause giv	on mr are r				pably 4 Unknown
ords, P.O. w requires that as been signed be should be detailed	교											
request peer houl	<u>e</u>								24a. Was auto			topsy findings available completion of cause of
CO law law e a s	립								perfo	ormed?	death?	·
Division of Vital Records, isl or Attending Physician: The law requirers after death.  al Director: After this certificate has been sided in by the funeral director, page 2 should be	Completed									2 No	1 🗸 Ye	es 2 No
tal ian: certif	BB	25. Was case referred to medica examiner?	-					f Death (Check	only one)			
Vit hysic I dire	٥	1 ✓ Yes 2 No	Hospital:	1 Inpatier	nt 2 ER	/Outpatient	3 DOA	ther Nursi	ng Home 5	Residence	5 🗸 Other	r: Scene
n of ing Pt After funeral	[ <u>-</u> ]	27. Manner of Death	288	a. Date of Injur (Month, Day,Ye	y 28	b. Time of Inju	ury 28c. Injury	at Work?		how injury occ	curred	
ri th. He fu	⊡	1 Natural 5 Pen		d 10/8		1 3:40	nm 1 Ye	s 2 No	unk			
Arte	Sa	(A)	Stigation 28				factory, office bui	ilding etc.	28f. Location	Street and Nu	mber or Ru	ral Route Number, City
Divisition At the constant of	Certification:	dete	a not be		ouse	, 10, 04.001,	Tablery, emiss but	indiring, otto.	Frederi	State) 14 I CK, MD	3. B. K	ral Route Number, City ey Parkway
Spits nours nera	ပ္ပ	4 Homicide	(3	pecity)		_			ricacii	city IID		
e Ho 24 h ; Fun etely		29a. Certifier 1 Certifying P	hysician: To	the best of my	knowledge,	death occurre	d at the time, date	and place, and	d due to the cau	se(s) and man	ner as state	ed.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical Exa	miner:On the and ma	basis of exan anner stated,	nnation and/o	or investigation	n, ın my opinion, o	death occurred	at the time, date	and place, an	a due to th	e cause(s)
F * F 3	Me	29b. Signature and title of certifi					29c. License	number		29d, Date s	igned (Moi	nth, Day, Year)
		Vando it-	ne CX	all			O.C.M	.E.		October	9, 2010	
		mortance 1	1-0-0									
		30. Name and address of person					an Street Dal	timore MD	21201			
4		Margarita Korell MD.										
	tate	31. Date filed (Month, Day, Year)	2010	32. Registrar		. San	Kel					
Regis	trar	001 2	· GUTU	presson	- mar find	· See See	_					

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				1 - For State Registrar	State o	f Marylar		artmen rtificat				lental Hyg	giene Reg. No.	010	33726	
		Physici		1. Decedent's Name (First, Middle Sadie Marie Ga		o h						2. Date of Dea Month October	Day	2010	3. Time of Death 3:05 A M	
		/Medi Examir		4a. Facility Name (If not institution				4b. City,	Town, or	Location		<u> </u>		ounty of Deat		
	1	Zami		Harford Memori	ial Hospit	tal		Havi	re de	2 Gra	ce			Harfor	.d	
		Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🗶 F	7. Age (In yrs. 83	last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day	h /, Year)	Co	hplace (State or Foreign	
		Director		246-36-2718 Usual Residence of Decedent	10 244.		Yrs.					08/16/	1927	Nor	th' Carolina	
10		/land		10a. State 10b. County		10c. Ci	ty, Town or L	ocation							10d. Inside City Limits	
0		Man	tor	MD Cecid	·	Pos	rryvill	2.0							1 ☐ Yes 2 🛣 No	
3		ith the Marylar or 28a-f ehow e notified at	)ire	10e. Street and Number				10f. Zip	Code				10g. Citize	on of What Co	ountry?	
0		death with the Maryland me 23a or 28a-f ehow r must be notified at	Ta I	143 Bayscape 1					1903					I.S.A.		
)		er de litera	Funeral Director	11. Marital Status	Armed Fo		J.S. 13.	Was Deced If Yes, spec	dent of Hi cify Cuba	ispanic Or n, Mexicai	igin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)	14	I. Race - Ame Black, Whit		
	36	irs aft	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	If Vas Gi	ve		1 🗆 Yes	2 <b>X</b> ) No	Specify:			S	Specify: U	lhite	
	9	72 hours after naturei', or ite ilcal Examine		15. Deceden	t's Education st grade completed)		16a. Dece	dent's Usua kind of wo	al Occupa	ation	et of worki	ina	16b. Kind	d of Business		
^	21	ithin 7	nple	Elementary/Secondary (0-12)	College (	1-4or 5+)	life.	DO NOT u	se retired	i)	N OF WORK	,,,,,				
0	121	led w lygier lygier her th	Be Completed	12	(		Home	emake	t	10 14-15		e (First, Middle,		lome		
_	and	ntel H	Be	17. Father's Name (First, Middle, Benjamin Frank	,							olelia :				
0 0	2	12 should be filed within "h and Mentel Hygiene." 7 ie marked other than "reumatic event, the Mag	ပ္	19a. Informant's Name/Relations			19b. Mail	ing Address	(Street			al Route Numbe			Zip Code)	
$\overline{}$	S	nd 2 salth ar 27 ie		Glenn Miller									200			
5	Je,	of Hei		20a. Method of Disposition			Place of Disp cemetery, cre	osition (Nar	ne of other place	e)	(	Frisco Sate	20c. Loca	ation - City or	Town, State	
	imo	Page nent d ant: if		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			laryland									
	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mentel Hygiene. Important: if Item 27 is marked other than "naturel", or items 23a or 28a-4 show important: if Item 27 is marked other than "naturel", or items 23a or 28a-4 show in pirty or other treumatic event, the Madical Examiner must be notified at SDES.	1	21. Signature of Funeral Service	Uman F											
	/	007 4 0		( raia c	, July	•		ie Grae	Approximate							
Sadie	38760,	death certificate be executed  By Again  Be ettending physicien and for use as the burial-transit.	dical Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):												
IIEC	O. Box 6	it the death certific by the ettending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	tcome of pregn birth 2 Fet nant at time of a	al death 3	□Ectopic p □ Other (s <sub>f</sub>		'			23	3d. Date of de Month	livery Day Year	
3	rds, P	es tha igned be del	5	Part II. Other significant conditi	ons contributing to c	leath but not re	sulting in the	underlying o	cause giv	en in Part	1.		obacco us Yes 2□		o the cause of death?	
01	Record	aw requir	Completed									24a. Was		24b. Were a	utopsy findings available	
N	Ä	an: The liticate he	E	aut pei 1  Yes										death?	completion of cause of	
N	Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medica examiner?	l .					26. Plac	e of Deat	h (Check only o	No No			
	of V	Physician: this certificated ral director, I	ုင္	1 ☐ Yes R No		-	☐ ER/Outpatie			4 🗆 14	ursing Ho	ome 5 ☐ Resi			ecify)	
4		ding P	<u>0</u>	27. Manner of Death  1√2 Natural 5 ☐ Pendi	ig .	of Injury oth, Day Year)	28b. Time Injury		28c. Injur Wor		111-	28d. Describe	how injury	occurred		
0	Division	or Attendition death	Certification:	2 Accident invest 3 Suicide 6 Could 4 Homicide deterr	nined 289. Plac	e of Injury - At h ling, etc. (Spec	nome, farm, s	M treet, factor		Yes 2	INO	28f. Location ( City or To		Number or R	tural Route Number,	
		To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	edical C	29a. Certifier 42 Certifyi (Check only one) 2 Medical	ng Physician: To th Examiner: On the t and mar	e best of my kn pasis of examin oner stated.	nowledge, dea nation and/or i	ith occurred nvestigation	at the tir	ne, date a pinion, de	nd place, ath occur	and due to the red at the time,	cause(s) a date and p	and manner a place, and du	s stated. e to the cause(s)	
		To th Withir To th	M	29b. Signature and title of certific	er /	-/		29	c. Licens	e number	of a	9	29d. Date	signed (Mon	th. Day, Year)	
				Tulanas	4, Me	de	W		1	14.2	30C	)	/	0/10/1	0	
-		7		30. Name and address of person	who completed cau	selfideath (Ite	om 23a) (Type	Print) 25	16	11/5	the	4 HA	6. n	lul à	21078	
		St Regist	ate rar	31. Date filed (Month, Day, Year	32.	Registrar's Sign	nature	hark	1			1		7		

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Maria esta			1 - State of Maryland / Department of Health and Certificate of Death		Reg. No.	10	33727
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Reginald Oliver Grant Sr.	2. Date of De Month Oct. 5	2010		3. Time of Death 9:50 PM
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of De	eath	4c. Co	unty of Death	
			Bowie Health Center Bowie			ice Ge	
	Funeral Director		5. Social Security Number  5. 79 - 54 - 7627  Usual Residence of Decedent  6. Sex  7. Age (In yrs. last birthday)  6. Sex  7. Age (In yrs. last birthday)  6. Sex  Yrs.  1f Under 1 Year   If Under 24 F   Months   Days   Hours   M	15. 8. Date of Bir (Month, Da 4 / 4 / 1 9	v. Year)	Coun	lace (State or Foreign try) ngton, DC
	the Maryland 28a-f show notified at	or	10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits
	the 1	Director	MD Prince Georges Bowie  10e. Street and Number 10f. Zlp Code		10g. Citizen	of What Cour	ntry?
	with Ba or t be	٥			IIn i +	ed Sta	tos
	Jeath mus	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	(Specify Yes or No		Race - Americ	an Indian,
920	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Menfal Hyglene. I then 27 is marked other than "natural", or Items 23a or 28a-f show then traumatic event, the Medical Examiner must be notified at	by	Armed Forces?  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced  Armed Forces?  1 □ Yes 2 □ No If Yes, Give 1966 / 1 □ Yes 2 ☑ No Specify:	Jerto Rican, etc.)		Black, White,  Decify: Bla	
Maryland 21215-0036	n ''natur n ''natur Medical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Eiementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	working	16b. Kind	of Business/Ind	dustry
212	filed within Hygiene. other than "	E O	1 Fire Chief		Pub.	lic	
٦	e filed al Hygi other vent, tl	Be	17. Father's Name ( <i>First, Middle, Last</i> )  18. Mother's N	Name (First, Middle	, Maiden Su	rname)	
<u> a</u>	ould be Mental narked o	10.	Clarence P. Grant Dorot	thy Snee	ed		
a	2 sho and is ma		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number of		er, City or T	own, State, Zip	Code)
2	and lealth m 27 her tr		Flora Grant Wife 6504 Lisa ln Bow	ie, MD 2	20720	· 0: T	. 0
O.	ges 1 If of H If ite		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State			ion - City or To	
Baltimore,	t. Pa ntmen ntant;		4 Donation 5 Other (Specify) Lincoln Memorial 10	/14/2010	Sui	tland,	MD
Bal	permit. Pages 1 and 2 s Department of Health at Important; if item 27 is any injury or other trau		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  W. Wesley Chavis  10684 Southern	MD_BLVI	Dun]		MD 2075
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as can shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Lung Cancer  Due to (or as a consequence of):  Sequentially list conditions,	diac or respiratory a	arrest,		Approximate Interval Between Onset and Death
68760,	ificate be executed j physician and as the burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):				
.O. Box	ath certif attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		230	d. Date of delive	ery Day Year
rds, P.	w requires that the de been signed by the s should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		tobacco use Yes 2□		he cause of death?
Reco	e la has e 2	Completed		24a. Wa. autr per 1∐ Yes	formed?	death?	opsy findings available impletion of cause of
ita	ysician; This certificate director, pag	Be C		Death (Check only	one)		
Division or Vital Records,	iing Phys After this funeral dir	Certification: To I	1   Yes 2 X No	28d. Describe	how injury o	occurred	fly Health Cer
_	Hospita 24 hours Funeral tely filler	edical Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and proceeding the control of the control of the process of examination and/or investigation, in my opinion, death of and manner stated.	place, and due to the occurred at the time	e cause(s) a e, date and p	nd manner as s lace, and due	stated. to the cause(s)
	ro the vithin 2 ro the comple	Me	29b. Signature and title of certifier 29c. License number		29d. Date	signed (Month,	Day, Year)
	- > - 0		D45880		Oct	11, 20	10
2	7		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		WL.	11, 20	10
No.	St Regist	ate rar	Leon Hwang 1221 Mercantile Lange Largo, Md. 20774  31. Date filed (Month, Day, Year)  OCT 1 4 2010  August 1221 Mercantile Lange Largo, Md. 20774				

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State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of M		partment of l e <i>rtificate of l</i>			ene .g. N2 0   0	33728			
			Decedent's Name (First, Middle,	Last)				2. Date of Death	1	3. Time of Death			
	Physicia Medic		Mary D.	Green				oct. 5,	2010 Year	7:20 A M			
	Examin	er	4a. Facility Name (if not institution, Prince George 1s	•	'enter		r Location of Death ${ t everly}$		4c. County of Dea	e George's			
	Funeral			6. Sex 7. Ag	e (In yrs. last birthda)	) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	g. Bi	irthplace (State or Foreign			
ı	Director		579-50-9767	1 □ M 2 🖾 F	76 Yrs.	Months Days	Hours Min.	July 24,	1934 So	outh Carolina			
	and show	or	Usual Residence of Decedent  10a. State 10b. County	-	10c. City, Town or	Location				10d. Inside City Limits			
	Maryla 28a-f	rect	DC				Washingt	on		1 🏻 Yes 2 □ No			
	th the	alDi	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What C				
	ath wi	Funeral Director	3417 Stanton Ro	ad SE  12. Was Decedent B	Ever in U.S. 1:	3. Was Decedent of H	0020 lispanic Origin? (Sp	ecify Yes or No-	United				
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	Armed Forces?		If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	Black, Whi	te, etc.			
5-0	"2 hou "natu edical	Completed		t's Education st grade completed)	j (Git	cedent's Usual Occup	during most of work	king .	16b. Kind of Business	s Industry			
12	rithin 7 lene. r than	Com	Elementary/Seconday (0-12) 9th	College (1-4 or 5	5+) life.	Nurse s	Assistan	nt	Priv	ate			
bu	filed wall Hyg	Be	17. Father's Name (First, Middle, L.					ne (First, Middle, M					
Уa	uld be Ment narke	입	Dan Sing					Elizabet	h Moye				
Mai	2 shoulth and 27 is r		19a. Informant's Name/Relationsh  Irene Lathern -			ailing Address (Street : 3 Stanton		al Route Number, ( <b>Washingt</b>	•	(ip Code) 0020			
Baltimore, Maryland	age 1 and ent of Hea nt: If item y or othe		20a. Method of Disposition  1   Burial 2 □ Cremation  4 □ Donation 5 □ Other (S)	3 Removal from State	20b. Place of Dis	position (Name of rematory or other place	-		20c. Location - City o				
Balti	permit. F Departm Importar any injur	100	21. Si nature of Funer   Service Li	_	111	ncoln 22. Name and Addre 4001 Benni	ss of Facility St						
			23a. Part Finter the disease or shock of heart failure. List o	complications that caused	the death. Do not e					Approximate Interval Between			
- 4	Physician Medical	i i	Immediate Cause (Final disease or condition resulting in death)	- Res	pirator	Fall	ure			2 nset and Death			
	Examiner		resulting in death)	Due to (or as	consequence of):	· Rren	st Can	000		Years			
	d sit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence oi):				=====	1 000 5			
	icate be executed physician and s the burial-transit	Exar	Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as	a consequence of):								
တ္တ	te be e nysicial ne buri	dical		d									
3876	artificat ling ph e as th		IF FEMALE:	220 If you guitagema	of programa								
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal death 3	☐ Ectopic pregnand ☐ Other (specify)	ру		23d. Date of d	elivery Day Year			
ls, P.O.	requires that the de been signed by the should be detached	þ	Part II. Other significant condition  Bilateral F	ns contributing to death b	out not resulting in the	e underlying cause giv	ven in Part I.	23e. Did toba	1	to the cause of death?			
Division of Vital Records,	ne law req e has bee age 2 shou	Completed	AnoxIC En	cephalo	pathe	<b>}</b>		24a. Was an autopsy perform	prior to death?				
<u>la</u>	sician: The certificate rector, pag	Be C	25. Was case referred to medical examiner?			26. PI	ace of Death (Chec		No 1 □ Ye	es 2 🗆 No			
₹	Physic this ce al dire	욘	1 ☐ Yes 2 No  27. Manner of Death		ent 2 ER/Outpat		4 LI Nursing H		nce 6 Other (Spe	ecify)			
o uo	f or Attending Phys after death. Director: After this i in by the funeral di	Certificate:	1 Natural 5 Pending 2 Accident Investig 3 Suicide 6 Could r	ation		work	y at (? Yes 2 \( \sum No	28d. Describe hov	v injury occurred				
Divis	To the Hospital or Attending Physician: The Is within 24 hours after death.  To the Funeral Director: After this certificate ha completed filled in by the funeral director, page		4 ☐ Homicide determi	ned 28e. Place of Inju				City or Town,					
	To the Hospital within 24 hours To the Funeral completed filled	Medical	(Check 2 Medical E	Physician: To the best of kaminer: On the basis of e Nurse Practioner: To the	xamination and/or inv	estigation, in my opinio	on, death occurred a	t the time, date and	place, and due to the	cause(s) and manner stated.			
	To the within To the complex		29b. Signature and title of certifier	28		29c. License			d. Date signed (Mon				
	)		30 Nama and address (	Kleen	anth (ltc= 02=) T	D a	21428		Uctober	5,2010			
2	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Linda D. Green 7582 Annapolis Rd. Lanham Md 2078K										
	Stat Registra		31. Date filed (Month, Day, Year)  OCT 1 2 2010	Serena S.	ar's Signature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Mary		tificate of E		пиена пу	Reg. N		
	Physicia		Decedent's Name (First, Middle, Last     Carmen	Marie		Giron		2. Date of De Month October	ath	2010	8:00 A M
	Medic Examin		4a. Facility Name (if not institution, give s			4b. City, Town, or Oxon Hi			4	c. County of Death	
	Funeral		806 Broderick Dri 5. Social Security Number 6. Se.		vrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hi Hours Mil		th	9. Birth	place (State or Foreign
	Director		Usual Residence of Decedent		Yrs.			11717/	1910		rto Rico
	//arylanc 8a-f sho tified al	Director	10a. State 10b. County  Maryland Prince Ge		c. City, Town or Loc	cation kon Hill					10d. Inside City Limits 1 ☐ Yes 2 🕱 No
	vith the M 23a or 2 st be no		10e. Street and Number 806 Broderick Drive		-	10f. Zip Code 207	45		10g. C	itizen of What Cou USA	entry?
	r death w r items	-	11. Marital Status  1★Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces?	n U.S. 13. V	Vas Decedent of Hi f Yes, specify Cubar	spanic Origin? ( n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		14. Race - Ameri Black, White,	
903	ours afte tural", c al Exam	ted by	3 🗌 Widowed 4 🗌 Divorced	1 Yes 2 No If Yes, Give Year or Dates.		XXYes 2 ☐ No		Rican		Specify:	White
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Seconday (0-12)	de completed)  College (1-4 or 5+)	(Give I	lent's Usual Occupa kind of work done d O NOT use retired) Stylist	ation uring most of w	orking	1	Kind of Business Ir ⊖auticiar	
nd 2	filed wit al Hygie d other event, th	Be	17. Father's Name (First, Middle, Last)	years	naii	Stylist		ame (First, Middle,	Maider		
aryla	d 2 should be falth and Menta 27 is marked 127 is marked 11 tranmatic ev	욘	Francisco Giron  19a. Informant's Name/Relationship (Type		19h Mailir	g Address (Street a	Americ			or Town State Zin	Code)
e, K	and 2 sh Health ar em 27 is ther trat		Carmen R. Giron / N	iece	806	Broderick D		HIII, Mar	ylan	1 20745	
Baltimore,	Page 1 ament of hant: If ite		1 ☐ Burial 2 ★ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Ob. Place of Dispo cemetery, cren Kalas C:	sition (Name of natory or other place rematory	10/	Date 12/2010		_ocation - City or T gewater,	
Balt	permit Depart Import any inj once.		21. Signature of Funeral Service License	on on one	22	. Name and Addres 5160 Oxon H	s of Facility (	eorge P. K Oxon Hill,	alas Mar	Funeral Ho yland 20	ome PA 1745
Ę	u=v=v		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on Immediate Cause (Final	ications that caused the ce cause on each line.	death. Do not ente		g, such as cardia	ac or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)	a Due to (or as a con		A					
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a con	sequence of):						
	tificate be executed ng physician and as the burial-transit	nedical Examiner	Cause: (Disease or impury that initiated events resulting in death) Last	Due to (or as a con	sequence of):						-
260	physicia the bur	edical		d							
P.O. Box 68760	ith cer ittendii or use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ★★No 9 ☐ Unknown	3c. If yes, outcome of pre 1  Live Birth 2  4 4  Pregnant at time 9  Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	у			23d. Date of delive Month	very Day Year
P.O.	es that the dea signed by the a l be detached f	by	Part II. Other significant conditions col	ntributing to death but no	t resulting in the u	nderlying cause giv	en in Part I.				he cause of death?
ords	v requires s been sig should b	Completed						24a. Was	an	24b. Were auto	obably 4 Unknown  opsy findings available
Rec	<b>hysician:</b> The law nis certificate has I director, page 2 !		25. Was case referred to medical					1 🗆 Yes	rmed?	death?	2 No
Vita	nysiciar nis certii directo	To Be	evaminer?	lospital:	2  ER/Outpatier	Otho	r: 4  Nursing		dence	6 ☐ Other (Specif	y)
on of	nding Pł ath. r: After th e funeral	Certificate:	27. Manner of Death  1¾  Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Yea	28b. Time of injury	28c. Injury work' M 1 □		28d. Describe h	now inju	ry occurred	
Division of Vital Records,	al or Atte after de Director d in by th		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe		eet, factory, office		28f. Location (S City or Tov		nd Number or Rura e)	l Route Number,
_	To the Hospital or Attending Phy within 24 hours after death.  To the Funeral Director: After this completed filled in by the funeral or	Medical	(Check 2 Medical Examin	cian: To the best of my kner: On the basis of examine Practioner: To the best of	nation and/or invest	igation, in my opinio	n, death occurre	d at the time, date a	and plac	e, and due to the ca	ause(s) and manner stated.
	V To the comp	2	29b. Signature and title of certifier	- Tuotioner to the Best	or my knowledge, c	29c. License		siace, and dde to th	29d. D	ate signed (Month,	Day, Year)
•	(0		30. Name and address of person who co			rint)					
	Stat		Ivan Zama 31. Date filed (Month, Day Year) 10 2 2000	92 Registrario Si	inpeturo	rt #200 L	argo, M	aryland	207	774	
	Registra	ar	OUT IZ ZUIU Ch.	MALL DO. A	sall!						

			for State Registrar	State of Ma	i yianu / i		tificate of			Glen	7 II I II	33730
	Physici		Decedent's Name (First, Middle MAYNARD	le, Last) MITCHELL	GII	LROY	/ JR.		2. Date of De Month OCTOB	Da	19 201	3. Time of Death 5:20P M
	/Medio Examin		4a. Facility Name (If not institutio 8310 GILROY				4b. City, Town, o	r Location of Death		1	CHARL	th
-4"	Funeral	Г	5. Social Security Number		(In yrs. last bii	rthday) _ Yrs.	If Under 1 Year Months Days		8. Date of Bir (Month, Da JUNE	th y, <u>Y</u> ear		thplace (State or Foreign Quatry) ARYLAND
	Director		Usual Residence of Decedent						JUNE	21,	1946 M	
	ath with the Marylan 23a or 28a-f show	to	MD CHA	ARLES	10c. City, Tow							10d. Inside City Limits 1 ☐ Yes 2 No
	or 28a	Director	10e. Street and Number				10f. Zip Code			10g. C	itizen of What Co	•
	ms 23a	Funeral	8310 GILROY	12. Was Decedent Ev	ver in U.S.	13. W		662 Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No	-	U. S.	
5-0036	hours after death with the Maryland tural", or items 23a or 28a-f show at Exprehent and the notified at	þ	1 ☐ Never Married 🏖 🖳 Mar 3 ☐ Widowed 4 ☐ Divorced	If Vas Giva		1	Yes, specify Cuba		Rican, etc.)		Black, White Specify: WH	
15-0 -	n 72 ho "natur	Completed	(Specify only highe	nt's Education est grade completed)	16a	. Deced	ent's Usual Occup	pation during most of work d)	king	16b. F	Kind of Business	
212	filed within 72 Hygiene. other than "na ent, it e Medic	Comp	Elementary/Secondary (0-12)	College (1-4or 5+				RDINATO	R			VERNMENT
Maryland	be od o	To Be	17. Father's Name (First, Middle, MAYNARD M.	GILROY, SR	•			18. Mother's Nam	e (First, Middle A FAY		,	
Mary	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		19a. Informant's Name/Relations					and Number or Ru		-		Zip Code) ND 20662
_	ges 1 and 3 it of Health If item 27 or other tr		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation		20b. Place o	f Dispos	ition (Name of atory or other place	ce) OCT	SER		ocation - City or	
gaitimore,	t. Par rtmen rtant: njury		4 Donation 5 Other (S	Specify)	GILR	DY I	PAMILY	CEM 23,2				, MARYLAND VICE, P.A.
ñ	perm Depa Impo any Ir		Joun B	A 50	M00641		535 WAS	HINGTON	AVE.,	LA	PLATA,	MD 20646
. T	Physician		Immediate Cause (Final	r complications that caused to only one cause on each line	the death. Do	not ente				rrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a	consequence	of):		ence	-			
		Je.	Sequentially list conditions,	b. Due to for as a	COUNTRIE CO	of):		ne of				
	executer and al-transi	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence	of):	·					
<b>68/6</b> 0,	icate be executed physician and the burial-transit	Medical E		d	· 							
POX P	n certific nding p use as 1	n/Mec	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o							23d. Date of de	livery
Ď Ċ	Attending Physician: The law requires that the death certificate be executed er death.  er death.  by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/	in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	1 Live birth 2 4 Pregnant at 1 9 Unknown			Ectopic pregnand Other (specify) _	÷y			Month	Day Year
<u>ທຸ</u>	res that signed by be deta	by Ph	Part II. Other significant conditi	ons contributing to death but	t not resulting i	n the un	derlying cause giv	en in Part I.				o the cause of death?
cords,	w requil	leted							1 □	Yes 2	<del> </del>	robably 4 Unknown utopsy findings available
E He	: The la cate has page 2	Completed							auto		prior to death?	completion of cause of
VITAI	ysician is certifi director	To Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☐ No	Hospital:	nt 2 🗆 ER/O	ıtnatient	3 DOA Oth	26. Place of Deat			6 ☐ Other (Spe	noife)
10 nc	ding Ph .r After th funeral	ion: T	27. Manner of Death	28a. Date of Injury (Month, Day,	y 28b.	Time of Injury	28c. Injur Wor	ry at k?	28d. Describe			Joney
IIVISION	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death statement and the transtal Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	Certification:	2 □ Accident investi 3 □ Suicide 6 □ Could 4 □ Homicide detern	not be 290 Place of Injur	ry - At home, fa (Specify)	ırm, stre		Yes 2 □ No	28f. Location ( City or To	Street a wn, Stat	and Number or R te)	ural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in		Check only 2   Medical	ng Physician: To the best of Examiner: On the basis of	examination ar	e, death	occurred at the ti	me, date and place	, and due to the	cause(	(s) and manner a	s stated.
	To the within 2 To the comple	Medical	one) 29b. Signature and title of certifie	and manner state	ed.		29c. Licens				ate signed (Mon	
			20 Name and address of a	atter	oth /It 22 `	/Time = =	5a	835	)	10	1/20	10
			30. Name and address of person	, (20 x	1	7 O	3 (	ofla	ta	M	020	646
	Sta Registr		31. Date filed (Month, Day, Year)  OCT 2	7 2010 32. Registrar	rs Signature	. 4	terre					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **FRANCES** PATRICIA GARDNER OCTOBER 20 Day 2010 6:27 A M Medical 4a. Facility Name (if not institution, give street and number)
WILLIAMSPORT RETIREMENT 4b. City, Town, or Location of AMSPORT Examiner 4c. County of Death VILLAGE WASHINGTON If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 233-40-9359 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months 1757 1929 WESTY VIRGINIA Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director WILLIAMSPORT WASHINGTON MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 154 N. ARTIZAN STREET 21795 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces

1 Yes 2 No Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) HOMEMAK ER 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry OWN HOME Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name First, Middle Last) LAWRENCE HEDGES 18. Mother's Name (First, Middle, Maiden Surname) 2 BESSIE MILLER 19a. Informant's Name/Relationship (Type, Print)
NANCY KEYSER/DAUGHTER 19b. Mailing Address (Street and Number of Flural Floute Number, City of Town, State, Zip Code) 13244 SALEM CHURCH ROAD, HAGERSTOWN, MD 21740 20a. Method of Disposition
1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State OCT Da 2010 SMITHSBURG CREMATORY SMITHSBURG, MD 4 Donation 5 Other (Specify) and Address of Facility BROWN FUNERAL HOME, PO BOX 821, 327 W. KING ST., MARTINSBURG, WV 25402 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 PNo
9 Unknown Month Pregnant at time of death g Unknown Completed by

the Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 24 hours

Certificate: To Be

Medical

Part II. Other significant conditions		sulting in the underlying	3		se contribute to the cause of death?  No 3 □ Probably 4 □ Unknown
Anorexia	,			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2  No
25. Was case referred to medical examiner?			26. Place of Death (Chec	ck only one)	
1 ☐ Yes 2 No	Hospital: 1	ER/Outpatient 3 1	DOA Other: 4 Nursing H	fome 5 Residence 6	Other (Specify)
27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident Investigatic 3 ☐ Suicide 6 ☐ Could not		28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred
4 Homicide determined	200 Diago of Injuny At h	28f. Location (Street and	Number or Rural Route Number,		

29a. Certifier (Check

building, etc. (Specify) City or Town, State)

critifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month, Day, Year)

30. Name and add completed cause of death (Item 23a) (Type, Print) 0

32. Registrar's

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2010 ARNOLD October 11:30 PM WESLEY GOODEN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 X M 2 🗆 F Days Hours Min. 3/26/1938 VPRETNIA 236-56-3355 72 Yrs. Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD THURMONT 1 🗆 Yes 2 🖺 No 10f. Zip Code 21788 10e. Street and Number 12815 CATOCTIN FURNACE ROAD 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces**◊** 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Race - Alice Black, White, etc. WHITE 1 Never Married 2 Married ð 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MINISTER 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) RELIGION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
NINA MORRIS ပ OSCAR GOODEN 19a. Informant's Name/Relationship (Type, Print)
THERESA JANE GOODEN/SPOUSE 19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12815 CATOCTIN FURNACE RD., THURMONT, MD 21788 20a. Method of Disposition
1 A Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State ROSEDALE CEMETERY MARTINSBURG, WV 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License e and Address of Facility BROWN FUNERAL HOME, PO BOX 821, 327 W. KING ST., MARTINSBURG, WV 25402 22. Name and Address of Facility 100De 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ a. Myocordial I disease or condition resulting in death) Medical Examiner oronary Arter Sequentially list conditions, if any leading to improve cause. Enter Underlying Examine Die to (or as a rounsequence of): sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury Due to (or as a consequence of): that initiated events resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be de Be Completed by Diabetes, Stroke 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Yes 2 X No 1 Yes 2 No ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Certificate: To 1 🗌 Yes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after To the Funeral Direct Medical King Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the 29b. Signature and title of 29d. Date signed (Month, Day, Year) DØØ35267 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 400 W

Casiano

Manuel A
31. Date filed (Month, Day, Year)

7th St

Frederick, mD 21701

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Baltimore, Maryland 21215-0036 To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

		_ For	Pleas	<b>e Type or Pri</b> State of M					k. Ensure Health and	-		•	ble.		
		State Registrar							Death		Reg.	0.0	In.	33.	733
Physician Medica		1. Decedent's Name		ast) Hyman						2. Date of OC to	<sub>Death</sub> ber	Day , 2	·610	3. Time of 0	
Examine	er			ve street and number)					r Location of Deat		- 1	4c. County o			
Funeral		5. Social Security No.		L1 Drive	e (In vrs. la	ast birthday)		er 1 Year	er Spri			Monto		ry lace (State or	Foreign
Director		578–11–6 Usual Residence of		1 M 2 K F	0	Yrs.	Months	Days	Hours Min.		Day, Year	19 <b>3</b> 9 P	Count	(rv)	
a-f shov	Director	10a. State MD	10b. County  Montgom	ery		y, Town or Lo ver Spri				-			1	0d. Inside City	
or 28e		10e, Street and Num						ip Code			10a.	Citizen of W	hat Coun		2 (8) 140
s 23a ust b	Funeral	9205 Ne	w Hampshi	re Avenue Uni	t B-3		20	903			US			,	
item ner n		11. Marital Status		12. Was Decedent 8 Armed Forces?	er in U.S		Vas Dece	edent of H	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No Rican, etc.)	0-	14. Race	- America		
	ted by	1 Never Mami		1  Yes 2  If Yes, Give Year or Dates.	No				Specify:			Specify:	As <b>i</b>		
"nat ledica	Completed	(Spec	15. Decedent's cify only highest	Education grade completed)			kind of w	ork done	during most of wo	rking	16b.	. Kind of Bus	siness Ind	lustry	
r thar	ទី	Elementary/Seco	onday (0-12)	College (1-4 or 5	i+)	Elderl		se retired) e Pro			Hea	alth Ca	re		
d othe		17. Father's Name (F		•					18. Mother's Na				10		
Ment marke natic	۵		io Posada			1			Paulina S	Sales					
Ith and 27 is r traun		19a. Informant's Na		(Type, Print) <b>/ Daughter</b>			-		and Number or Ru					ode)	
of Hea item other	ŀ	20a. Method of Disp	osition		20b. P	lace of Dispo	sition (Na	ame of	Way, Monto	Date Date		Location - 0	<b>20886</b> City or To	wn, State	
ant: If			☐ Cremation 3 5 ☐ Other (Spe	Removal from State		emetery, crer a Iloil			Octob	er 30 20	010 Sa	ra, Il	oilo, E	hilippi	nes
Depart Import any inj		21. Signature of Fun	neral Service Lice	nsee		22 <b>F</b>	. Name a	and Addre	ss of Facility Collins Fur ity Blvd.,	eral Hon	e, Ir	ıc,	m 000	201	
	$\dashv$	23a. Part 1. En er th	ne disease, or co	mplications that caused	the death	n. Do not ente	er the mo	de of dyin	g, such as cardiac	or respiratory	er Sp arrest,	ring, I	<u>MD 209</u>	Approximate	
ysician/		Immediate Cause (F disease or condition	inal	one cause on each line		the Lu	nq						me	Interval Betw Onset and De Onths	
Medical xaminer		resulting in death)	-	Due to (or as	a consequ	ence of):							118	aidis	
	Jer	Sequentially list cor if any, leading to im cause. Enter Under	nditions, mediate	b. — Due to (or as	a consequ	ence of):							-		
D <sub>a</sub> isi	Examiner	cause. Enter Under Cause (Disease or i that initiated events	injury	c											
		resulting in death) L	ast	Due to (or as	a consequ	ence of):									
physic sthe b				<b>d</b>											
within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physi completed filled in by the funeral director, page 2 should be detached for use as the total management of the funeral director.	<b>—</b> I	IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?	23c. If yes, outcome 1  Live Birth 4  Pregnant a 9  Unknown	2 Feta	Ideath 3	Ectopic Other (s	pregnanc	су			23d. Date Mont		ry Day Ye	ar
signed by	음			contributing to death b	ut not resi	ulting in the u	nderlying	cause giv	ven in Part I.					e cause of dea	
should	ere	Congesti	ive Heart	Failure						24a. W				sy findings av	_
page 2	Completed		Mellitus							au pe	topsy rformed? s 2	pr de	ior to con eath? Yes	npletion of cau	use of
certific rector,	ן מֿ	25. Was case referre examiner?		Hospital:				Oth	ace of Death (Che					_Second	
eral dii	0 :	1 ☐ Yes 2 🗶 27. Manner of Death		1 Inpatie	y	ER/Outpatien 28b. Time of	T	Othe 28c. Injur	4 LI Nursing r	lome 5 Re				Resider	ice
eath.	ertificate:	1 → Natural 2 → Accident 3 → Suicide	5 Pending Investigati		, Year)	injury	M	work		Edd. Booking	5 110 17 mg	ary coodinoc			
al Director led in by t	۱ د	4  Homicide	6 ∐ Could not determine	d 28e. Place of Injurbuilding, etc	. (Specify)	}				City or 7	own, Sta	te)		Route Numbe	Ş
in 24 hou	Medical	(Check 2	Medical Exa	ysician: To the best of niner: On the basis of earse Practioner: To the	kamination	and/or invest	igation, in	my opinio	on, death occurred	at the time, dat	e and pla	ce, and due t	to the caus	se(s) and mann	ier stated.
20 Son 1		29b. Signature and t					29	c. License	e number		29d. [	Date signed (	Month, D	ay, Year)	
2	}	30. Name and addre	_	completed cause of de	eath (Iter	Z3a) (Type, P					Luu		, 2010		
				MD 1355 Pica	ard Dr	ive Ste	. 100	, Rod	kville, MD	20850					
State Registrar	-	31. Date filed (Month	T 12 20	37. Registra	r's Signat	par	KI								

10-07781 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Adam Joseph Hosinski 010 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Adam Joseph Hosinski Medical Examiner 0323 hrs October 10, 2010 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 3551 Marinelli Drive Montgomery 5. Social Security Number 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY **Funeral** Months Davs Hours Director 213-29-5754 26 April 13, 1984 Country) MD 1 M 2 F Usual Residence of Decedent uпy 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State s 23a or 28a-f show e notified at once. 1 Yes 2 X No MD Montgomery Silver Spring permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygeine. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. rector 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 15104 Snowden Drive 20905 ö Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, 1 X Never Married 2 Married Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes Yes 2 No specify: White 3 Widowed 4 Divorced If Yes, Give Year Specify: è 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 2 Investigative Specialist Federal Government 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) John A. Hosinski Gloria Lopez Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) John A. Hosinski/Father 15104 Snowden Drive, Silver Spring, MD 20905 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery Date Baltimore, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 15, Oct. Gate of Heaven Cemetery 2010 Silver Spring, MD 4 Donation 5 Other Specify. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician 23a, Part I, Ente Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions iner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last death certificate be executed and sician/Medical UNPENDED **AMENDED** Box 68760 attending physior use as the bu 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Fetal death Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Phy The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? o signed ģ ۵. 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed Records, 24a, Was an 24b. Were autopsy findings available autopsy has performed? death? 1 🗸 Yes Yes 2 No

certificate To the Hospital or Attending Physician: within 24 hours after death. Division of Vital After this the Director: the Funeral

Be

Certification:

g

prior to completion of cause of 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other: Scene 2 ER/Outpatient 3 DOA 1 V Yes 2 No 28a. Date of Injury (Month, Day Year) Oct 10, 2010 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Pedestrian struck by auto Natural 0319 hrs 1 Yes 2 ✔ No 5 Pending 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 | Could not be or Town, State) 3551 Marinelli Drive, Rockville, MD determined (Specify) Major Road / Highway

CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201

O.C.M.E.

October 10, 2010

31. Date filed (Maoth State Registrar

Donna M. Vincenti, MD

4 Homicide

Assistant Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For AMEND#5 per FH State Registrar 10/19/2010 CMH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Many Physician/ JR. 0900 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 9505 Utica Place Springdale Prince George's **Funeral**  Social Security Number 226–62–3789 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 □ F Days (Month, Day, Virginia Hours Min. 1946 **Director** 226-70-3605 64 Jan. Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits Director MD 1 Yes 2 No Prince George's Springdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9505 Utica Place 20774 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces' 1 Never Married 2 Married Black, White, etc. Completed by X Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Divorced Year or Dates.1966-69 Black permit. Page 1 and 2 should be filled within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Police Captain FBT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Willie Hilliard, Sr. Viola Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Taylor-Hilliard/Wife 9505 Utica Place, Springdale, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Veterans Cemetery 10/15/2010 Cheltenham, 21. Signature of Funeral Service 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, 23a. Part 1. Enter the dispessions, or heart failure. ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ESOPHAGEAL > 14eas disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that the death certificate be executed and the bunal-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the bunal Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Dav Pregnant at time of death be detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed? Yes 2 No 2 No 1 Yes the Hospital or Attending Physician: completed filled in by the funeral director, **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Presidence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred 5 Pending injury after death. 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1' 🔀 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier sav 30. Name and address of person who completed cause of death tem 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Maryla				Mental Hy	giene	010	33736
		_	Registrar  1. Decedent's Name (First, Middle, Last	*	Cer	tificate of L	Jeatn	T	Reg. No.	7 1 0	
PI	hysicia	n/						Date of Dea     Month	Day	Year	3. Time of Death
	Medic		James Walte		oa			0ctobe		2010	7:00 a. M
1	Examin	er	4a. Facility Name (if not institution, give	,			Location of Death	1		nty of Death	
<u> </u>			21360 Cedar Hill  5. Social Security Number 6. Se		L-46146-4-3	Leonard		1		Mary	
	uneral rector			ZIM 2 DE	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da 08/17/	th y, Year)	Count	lace (State or Foreign (ry)
			Usual Residence of Decedent	90				108/1//	1920	<u> LConn</u>	ecticut
pu	at	5	10a. State 10b. County	10c. C	ity, Town or Loc	cation				1	0d. Inside City Limits
lanyla	3a-f sified	ect	Maryland St. Ma	rv's	reat Mi	i11s					1 ☐ Yes 2 🕱 No
he	or 2	۵	10e. Street and Number	-7 -		10f. Zip Code			10g. Citizen o	of What Coun	try?
with	23a ıst b	eral	46005 Strickland	Road		206	34		US	S A	
ath	ems er mu	Funeral Director	11. Marital Status	12. Was Decedent Ever in U	.S. 13. V	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No-		lace - America	an Indian.
ē ē	or it	by	1 Never Married 2 Married	Armed Forces?  1 Yes 2XXNo				o Rican, etc.)	В	lack, White, e	etc.
rs af	ıral", Exa	eq	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.	1	☐ Yes 2X No	Specify:		Spec	ify: Whi	te
Z1Z13-UU36 within 72 hours after giene.	natı ica	Completed	15. Decedent's Ed (Specify only highest gra	ducation		lent's Usual Occupa		lein a	16b. Kind of	Business Inc	lustry
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filec tal H	even	To Be	17. Father's Name (First, Middle, Last)	,,				ne (First, Middle,	_	ıme)	
yiana ild be filed Mental Hy	atic	-	Albert J.	Homewood			Edna	Lead	:h		
Niar 2 shou th and	: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Me-Ical Examiner must be notified at		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailin	ig Address (Street a	and Number or Ru	ral Route Numbe	r, City or Towr	, State, Zip C	code)
P, N	m 27 her tr		Jeffrey Homewood			0 Cedar	Hill La.	, Leonar	dtown,	MD 20	650
e la	If ite		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐		Place of Dispo- cemetery, cren	sition (Name of natory or other plac	e)	Date	20c. Locatio	n - City or To	wn, State
Pag ment	ant:		4 Donation 5 Other (Specify		insfiel	d-Echols	10/	19/2010	Char1	otte H	all, MD
<b>Saltimore,</b> permit. Page 1 and Department of Hea	Important: If item 2: any injury or other tonce.	ij	21. Signature of Funeral Service Lense	Carrie	22	. Name and Addres	ss of Facility Br	insfield	l Funer	al Hom	ne, P.A.
		3	Edward N. Brins	lield, Jr. MO	0052   2	22955 Hol	lywood R	d., Leor	nardtow	m, MD	20650
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or		ath. Do not ente	er the mode of dying	g, such as cardiac	or respiratory an	rest,		Approximate Interval Between
	ician/	0.8	Immediate Cause (Final disease or condition	Metasta	tic Pro	state Ca	rcinoma			8	Onset and Death  Vears
,	edical miner		resulting in death)	Due to (or as a conse	quence of):						
LAG		<u></u>	Sequentially list conditions.	b. —							
73	±	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (of as a conse	quence on.					- 1	
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ate p	physic the b	dic		d	****						
oo v	ling p	Physician/Me	IF FEMALE:	220 16 100 0140000 06 01000							
¥ Ç	ttenc or us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1 Live Birth 2 Fe	tal death 3 🗌	Ectopic pregnanc	у		1	Date of delive Month	
DOX death	the a	ysic	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	death 5 L	Other (specify)				VIOITIII	Day Year
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es th	signe be d	d by	Cardiomyopathy			,g g					pably 4 Unknown
	een	etec		<b>.</b>	-			1			
VITAI FECOLUS, ysician: The law requires	has t e 2 s	Completed	Atrial Fibrilla	CIOH				24a. Was autor	osy	prior to cor	psy findings available impletion of cause of
E =	cat.							1 Tes	rmed? 2X No	death?	
ician	ector	Be	25. Was case referred to medical examiner?	Hospital:			ace of Death (Chec				Son's
Physi	this all dir	은	1 ☐ Yes 2 🛣 No	1 Inpatient 2			4 ☐ Nursing H				Residence
ing Pi	After	ate	1 X Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	work	?	28d. Describe h	now injury occ	urred	
ttend	the i	tific	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be				Yes 2 ☐ No				
UIVISION tal or Attendii rs after death.	Direc in by	Certificate:	4 Homicide determined	28e. Place of Injury - At I building, etc. (Special		eet, factory, office		28f. Location (S City or Tow		nber or Rural	Route Number,
DIVISION Of VITAL RECORDS, P.O. BOX 06/00 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	filled		29a. Certifier 1 X Certifying Phys	ician: To the best of my kno	vlodgo dosti	noured at the time	data and elecc	and due to the			
<b>Hos</b> 24 h	Fun eted	Medical	(Check 2 L Medical Examin	ner: On the basis of examinati	on and/or invest	tigation, in my opinic	on, death occurred a	at the time, date a	and place, and	due to the cau	se(s) and manner stated.
o the	<b>o the</b> отр	Σ	only one) 3 ☐ Certifying Nurs  29b. Signature anyl title of certifier	e Practioner: To the best of	ny knowledge, d	29c. License		ice, and due to the	e cause(s) and 29d. Date sig		
F 3	<b>-</b> 0		> Miller MI	1500							
			30. Name and address of person who c	ompleted cause of death (the	m 22a) /Time 17	D0031	. 203		10/	18/2010	)
Tho			Charles Benner,			t Mills F	Road. Lev	cington	Park. 1	MD 206	53
	Stat	e	31. Date filed (MOCT Pay 1'9') 2010				.Jaa, Hen				
R	Registra	ar -	061 18 2010	2. Registrar's Sign	. gar	K.					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2010 Herbert Joseph Edward October 5:35 а. 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death St. Mary's Hospice House of St. Mary's Callaway . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland 1 X M 2 D F Months Days Hours Min 02/28/1932 78 217-32-0985 Usual Residence of Decedent 10b County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No St. Mary's Maryland Avenue 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 37990 Hatchet Thicket Road 20609 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3₺ Widowed 4 □ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10th Builder Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nellie Armstrong Joseph E. Herbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne Herbert/Grandson P.O. Box 203, Avenue, Maryland 20609 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/22/2010 Bushwood, MD Sacred Heart 4 ☐ Donation 5 ☐ Other (Specify) 21. Signame of F, ral Sa , Lieuse Ldward N. Brinsfield, 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Ŋr. M00052 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Yes 2 No Unknown 9 Unknown

Physician/ Medical **Examiner** 

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Certificate:

Medical

and

that the death certificate be executed

Box 68760

P.O.

Records,

Hospital or Attending Physician: Division of Vital

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completed filled in by

Physician/

Medical

Director

Funeral

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Completed

Be

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Examiner

**Funeral** 

Director

iral", or items 23a or 28a-f s Examiner must be notified

"natural",

and Mental F

permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve any injury or other traumatic eve once.

the Medical

filed within 72 hours after death with the Maryland all Hyglene.

Maryland 21215-0036

Baltimore,

Examine Physician/Medical IF FEMALE Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed

25. Was case referred to medical

29b. Signature and title of certifier

1 Tyes

27. Manner of Death

1 Natural

2 Accident 3 Suicide

4 Homicide

29a. Certifier (Check

2. No

5 Pending

Investigation 6 Could not be

determined

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autops Yes

. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

		2	6. Place of Death (Check or	ly one
1 Inpatient	2 ER/Outpatient	з □ роа	Other: 4  Nursing Home	5 🗌

28c. Injury at

Hospiel 4 Nursing Home 5 Residence touse

28	3d. [	Desci	ribe	how	/ inju	ıry (	occu	rred	
1									
10	26.1			·					_

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month. Dav. Year)

30. Name and address of rson who completed cause of death (Item 23a) (Type, Print)

Hospital

28a. Date of injury (Month, Day, Year)

40900 Merchants Lane, Leonardtown, MD 20650 Jennifer Schmidt 31. Date filed (Month Registrar's Signat OCT

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

injury

2 pme

State Registrar

		aı aı For	Please mend	Type or #18 Per State o	Print in INF GO of Marylar	Black II 10 12/ nd / Depa	ndelik 15/1 artme	ole Inl 0 JH nt of F	<b>k. Ensure</b> Health and	All Copie Mental H	es Are ygiene	e Legi	ible.	0070
	-	State Registrar							Death		Reg. N		IU	3373
Physician/	,	1. Decedent's Name (First, I		•						2. Date of D		av	Year	3. Time of Death
Medical	ıl .	James Hor								oct 7,				22:16P N
Examiner		4a. Facility Name (if not insti Suburban	Hos	pital		1-11-11-1-1	Bet	hes				c. County of	gom	ery
Funeral Director		5. Social Security Number  579-14-4643  Usual Residence of Decede	<u> </u>	EXM 2 □ F	7. Age (In yrs. 88	Yrs.	Months	Days	If Under 24 Hrs Hours Min		ay, Year)	2	Cou	hplace (State or Foreig intry) Shington
the Maryland or 28a-f show on outflied at	ctor	10a. State 10b. C	ounty	e Georg		ity, Town or Lo		bor	0					10d. Inside City Limits
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	rai Dire	10e. Street and Number 9590 Crair	n Hic	nhwav a	nt#12	7	10f. Z	p Code	2.2			Citizen of W		
death with the items 23a of the must be remust be	nue	11. Marital Status		12. Was Dece	dent Ever in U.		Vas Dece		ispanic Origin? (S an, Mexican, Puer	pecify Yes or No		S.A		ican Indian,
rmit. Page 1 and 2 should be filed within 72 hours after de partment of Health and Mental Hygiene. portant: If item 27 is marked other than "natural", or it y injury or other traumatic event, the Medical Examine ce.	≥	1 ☐ Never Married 2 ☐ 3 😿 Widowed 4 ☐ Div		Armed Fo 1XX/es If Yes, Giv Year or Da	rces? 2  No e 1 9 4 2 -	1			Specify:	to Rican, etc.)			k, White	, etc.
hour hatur	Slete		ecedent's f			16a. Deced			ation during most of wo	rkina	16b.	Kind of Bu	siness I	ndustry
within 72 hours at giene. ier than "natural" the Medical Exe Completed	Com	Elementary/Seconday (0		College (1		life. D Pos	stal	e retired)	cker	rking	U	S Po	sta	l Office
I be filed w fental Hyg rked othe tic event,		17. Father's Name (First, Mic Unavaila							_Hel	me (First, Middle en <del>ille</del> H			)	
2 should th and N 27 is ma trauma		19a. Informant's Name/Rela Vanessa Hut			er)	19b. Mailir	ng Addres	s (Street a	and Number or Ru	ıral Route Numb	er, City o	or Town, St	tate, Zip	codMD 2072 rmarlboro
1 and of Hea item other	1	20a. Method of Disposition			20b.	Place of Dispo	sition (Na	me of		Date Date				Titta LIDOL ( Town, State
Page ant: If ury or		1 🔀 Burial 2 □ Crem 4 □ Donation 5 □ O	iation 3 L ther <i>(Spec</i> i	J Removal from ffy)	State Md	veretery crem Vets	"Cem	eter	y 10/	18/201	∮ Cł	nelte	enha	am Md
permit. Departr Import any inji		21. Signature of Fueral Ser	vice licen	Masen		22	2. Name a	nd Addres Kenn	ss of FacilityRousedy St	ger J NW Was	Masc sh I	on Fu	une:	ral Servi
	1	23a. Part 1. Enter the diseashock, or heart failure.	se, or com List only o	plications that cone cause on ea	ch line.	th. Do not ente	er the mo	de of dyin	g, such as cardia	or respiratory a		<u> </u>		Approximate Interval Between Onset and Death
hysician/ Medical	İ	disease or condition resulting in death)		a	or as a consec	uence of):			y Arre				-	Onset and Death
Examiner		Sequentially list conditions,		b. ———			Ca:	rdio	myopath	ny				
kecuted and al-transit		Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or iinjury	~	Due to I	or as a curitieu	plante of,:							-1	
E E E		that initiated events resulting in death) Last	l		or as a conseq	uence of):				· · · · · · · · · · · · · · · · · · ·				
rtificate the plant of the base the base the base the base the base the base the base base base base base base base bas	Medic	IF FEMALE:		d										
To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burnament of the funeral director. To be completed by Physician/Medical	iysicidii	23b. Was decedent pregnan in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			Birth 2 🗌 Fet nant at time of	at death 3	Ectopic Other (s		<b>Э</b>			23d. Date Mor		very Day Year
that the ned by e detac	2	Part II. Other significant co	onditions o	ontributing to d	eath but not re	sulting in the u	nderlying	cause giv	ven in Part I.	23e. Did	tobacco	use contri	bute to	the cause of death?
quires en sig ould b						-				1 🗆	Yes 2	2 □ No	3 🗆 Pro	obably 4 🗗 Unknow
₹ 82 1	olube	1,30								24a. Wa auti per	s an opsy formed?	р	rior to c eath?	opsy findings available ompletion of cause of
cian: T ertifica ector, p Be C	ן מ	25. Was case referred to me examiner?	dical					26. Pl	ace of Death (Che		العام ا	10	103	24110
hysic this ce al direc	2	1 🗌 Yes 2 🔀 No		Hospital: 1	Inpatient 2	ER/Outpatier			4 ☐ Nursing I	Home 5 Res				fy)
ding F h. After 1 funera	iale:		ending	1 '	of injury th, Day, Year)	28b. Time of injury	м	28c. Injun work	yat :? Yes 2 □ No	28d. Describe	how inju	ry occurre	d	
or Attending P a er death. Director After t n by the funera Certificate:		3 Suicide 6 C	nvestigatio Could not b letermined	e 28e. Place	of Injury - At h	ome, farm, stre y)			763 2 110	28f. Location City or To			r or Rura	al Route Number,
To the Hospital or Attending Physician: The la within 24 hours ale death.  To the Funeral Director After this certificate ha completed filled in by the funeral director, page.  Medical Certificate: To Be Com		(Check 2 Med	lical Exam	iner: On the bas	is of examination	on and/or invest	tigation, in	my opinio		at the time, date	and plao	e, and due	to the c	ause(s) and manner sta
To the within to the comple	Ž	only one) 3 L Cert 29b. Signature and title of co		se Practioner:	To the best of m	ny knowledge, o		urred at the	e time, date and pl number	ace, and due to				btated.  Day, Year)
		► NAh	ALA	- M1				D	70241			10/	9/1	0
- VA		30. Name and address of pe Nadar Sha	nthi	MD 86	00 ol	d Geoi	rint) cget	own	Rd Bet	hesda	Md			
State		31. Date filed (Month, Day, Y	'ear)	32. R	egistar's Sign	Will.								

### Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month Yaar Physician Freddie Lee Hudgens 10/04/2010 3:55pm /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Deeth Examiner Futurecare Pinview Prince George's Clinton If Under 1 Yaar Months Days If Under 24 Hrs. Birthplaca (Stata or Foraign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Data of Birth (Month, Day, Yeer) **Funeral** Months 1 MM 2□ F Yrs Director 249-54-6684 78 06/22/1932 Usual Rasidance of Decedant Pages 1 and 2 should be filed within 72 hours aftar death with the Maryland nent of Haaith and Mental Hygiene. Int: If Item 27 is marked other than "naturel", or items 23s or 28e-f ehow 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 □ No Directo Prince George's Oxon Hill 10g. Citizan of What Country? 10e. Street and Number 2443 E. Rosecroft Village Cir. 20745 Funeral **NZA** 12. Was Decedant Evar in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Spacify Yas or No If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14 Bace - Amarican Indian Black, Whita, atc. 1 ☐ Yas 2 M No If Yes, Give Yaar or Dates: 1 ☐ Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 X No Specify: Spacify: Completed by Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Dacedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Factory Worker Burlington Industry 17. Father's Nema (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Sumama) Be Tally Hudgens Emma Jane Jackson 19b. Mailing Addrass (Street and Number or Rural Route Numbar, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) , and 2, and 2, went of Haalth ar. nt: If item 27 is vor other 2443 E. Rosecroft Village Cir., Oxon Hill, MD 20745 Pamela Hudgens / daughter 20b. Placa of Disposition (Name of cematery, cremetory or othar place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 70/06/70 Beltsville MD Chesapeake Crematory 21. Signature of Funeral Seprice Licent 22. Nama and Addrass of Facility Strickland Funeral Services 6500 Allentown Rd., Camp Springs, MD 20748 Entar tha disease, or com, or haart failure. List only Approximata Intarval Between Onset and Daath of complications that causad tha death. Do not antar the mode of dying, such as cardiac or raspiratory arrast, ist only ona cause on aach lina. **Physician** /Medical Immediate Cause (Final disaase or condition rasulting in death) Lung Cancer Examiner Due to (or es a consaquance of): Examiner bunal-transit or Attanding Physician: The law requires that the death certificate be axecuted Sequentially list conditions, if any, laading to immediata cause. Entar Underlying Causa (Disaasa or injury that initiated avants rasulting in death) Last physician and Due to (or as a consaguance of) Division of Vital Records. P.O. Box 68760. Physician/Medical the. Due to (or es e consequenca of): certificata has been signed by the a ractor, paga 2 should be datached is Part II. Other significant conditions contributing to death but not resulting in tha underlying causa givan in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? TLI Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Homa 5 ☐ Rasidance 6 ☐ Other (Specify) this funeral Certification: 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mannar of Death 28d. Dascribe how injury occurred 28b. Time of After 1 Natural 2 Accidant 5 Pending death. 1 ☐ Yas 2 ☐ No investigetion after death Director: A by the f 6 Could not be determined 3 Suicide 28f. Location (Straat and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 4 ☐ Homicida within 24 hours at To the Funeral D completaly filled i edical 29a. Certifiar (Check only one) 1 🗓 🎾 rtifying Physician: To the best of my knowledge, death occurred at the time, data and plece, and dua to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the tima, date and place, and due to tha cause(s) and manner stated. 29b. Signatura and titla of certifier 29d. Data signad (Month, Day, Yaar) 29c. Licansa numbar 1000 OCTORE 6. 2016 men 835206 30. Name end addrass of person who complated cause of daath (Itam 23a) (Type, Print) Pat washington, manyland TANNERM Livingetu Rond 11701 lilliam 31. Date filed (Month, Day, Year)
OCT 1 2 2010 32. Registrar's Signatura State Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCT. Physician/ 2010 MARGUERITE LOUISE JENIFER 24 4:00A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GENESIS WALDORF CENTER WALDORF CHARLES 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Min. 1 - 1 1 - 1 9 4 0 Months Days Hours 1 □ M 2 F 215-38-3369 70 N.Y. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at Director MD. CHARLES 28a-f WALDORF 1 🗌 Yes 2 🔀 No ò 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 4140 OLD WASHINGTON ROAD 20602 U.S.A. death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 No Specify: Specify: BLACK Completed 3 Widowed 4 NDivorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other this any injury or other traumatic event; the once. DOMESTIC WORKER SELF EMPLOYED 10th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ PHILLIP COLE AGNES BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA CANADA-DAUGHTER 8196 CALEDON RD. KING GEORGE, VA. 22485 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State TROPOLITAN CREMATORY 10-30-10 AGEX., VA. . Signature of Emeral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition **Medical** resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death signed by the a d be detached f Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed been signated by should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 🗷 No ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident
Suicide 1 🗌 Yes 2 🗌 No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 
Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar

27

9

ess of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10/05/2010 TONIA LOUISE JOHNSON М 1534 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 101 King Farm Blvd, #D105 Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F NY NY 08/03/1964 **Director** 090-56-5184 46 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 X Yes 2 ☐ No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 101 King Farm Blvd, #D105 20850 USA 12. Was Decedent Ever in U.S. Armed Forces?,
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify: Completed 3 Divorced 4 Divorced Specify: Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic miner. Elementary/Seconday (0-12) College (1-4 or 5+) IT Specialist Technology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leonard Johnson Naomi Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 733 Falls Grove Dr, #9022, Rockville, MD 20850 Lynda Johnson-Azzahid - sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 🗆 Donard 5 🗀 Other (Specify) crematory or other place cemetery 10/11/10 Silver Spring, MD οĒ Heaven 22. Name and Address of Facility Snowden Funeral Home Signature of Funeral Service Licer 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the deal not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lift only one nterval Between Immediate Cause (Final nset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the burial-transit Exami requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Completed by Physician/Medical use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy for 5 Other (specify) Pregnant at time of death Month Day detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of Hospital or Attending Physician: The law page 2 autopsy perform death? this certificate 2 No 2 🔼 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending of Funeral Director: Aft oleted filled in by the fur 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To prepest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

To the within 2

only one) 29b. Signature and title of certific

31. Date filed (Month, Day, Year)

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

**Division of Vital** 

Registrar DHMH 17 Rev 7/2009 y mo oma

mo oms

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

50\Q

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Day Shirley Y. Johnson 20 TO 0145 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel **Annapolis** Genesis Healthcare @ Spa Creek If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral u Youth, Pay Hours N Country arolina 1 □ M 2X F <sup>ea</sup> 937 73 Director 241-50-2991 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director Anne Arundel Annapolis 1 ☐ Yes 2 X No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1796 B Belle Dr. 21401 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. ò 1 Never Married 2 Married ģ 1 ☐ Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Specify: Black "natural", Completed 3X Widowed 4 □ Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel Co. and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Educator Public Schools 12th 4yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) þe James Williams Estelle Williams other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Rhonda Salazar (Daughter) 3222 Ravenwood St. Ann Arbor, MI 48103 Baltimore, 20a. Method of Disposition 20b. Ble stoppestice (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State injury or Memorial Park 10-11-10 Annapolis, Md. 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Williame Redeseed RecilitSons Mortuary, 821 West St. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying sician and burial-transit The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 70

9 Unknown Month Day Year Pregnant at time of death ed by the a P.O. s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 → Inknown Completed 24b. Were autopsy findings available 24a. Was an page 2 s prior to completion of cause of death? has autopsy performed certificate 2 No 1 Yes Division of Vital or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 ursing Home 5 Residence 6 Other (Specify) 2 Ko 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending injury 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fi Accident M Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signatur and title of cer 29c. License number 29d. Date signed (Month, Day, Year) 311 30. Name and person who completed cause of death (Item 23a) (Type, Print) COLONY 1-A TIDEWATER 2007

Registrar
DHMH 17 Rev 7/2009

State

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October Physician/ 10,2010 1305 Nancy Rutley King Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth (Month, Day, Year) Aug. 7, 1934 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. 1 M 2 Months Davs Hours Washington, DC 76 Director 217-32-0137 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🖪 No Maryland Montgomery Derwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 17546 Wheat Fall Drive 20855 U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Bace - American Indian Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ■ No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William Rutley Erma Vaughn Rutley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jannine Holden/Daughter 9217 Woodvale Road, Damascus, MD 20872 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Cemetery Oct.14,2010 Rockville, Maryland 21. Signature of Fundral Service Licensee 22. Name and Address of Facility.
Molesworth-Williams, P.A., Funeral Home
26401 Ridge Road, Damascus, MD 20872 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ acute myocardial disease or condition Medical resulting in death) Due to (or as a cons ence of) Examiner astrointestina Sequentially list conditions, Jue to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last the attending physician a hed for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) 9 Unknown ate has been signed by a page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 L Unknown obstructive 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed? Yes 2 No after death.

Director: After this certificate I

J in by the funeral director, page 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: ၉ 1 Yes 2 No 1 Inpatient 2 X ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🔀 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral C Medical 29a. Certifier 1 DCcrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Month, Day,

Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Amend#5.PerInfo	eme Fire	htPCC10-18-10cr Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. PCC10-14-10cr State of Maryland / Department of Health and Mental Hygiene
America 17.1e		State Amend#26 PerPhys PCC1014_10ccontificate of Poeth
		Decedent's Name (First, Middle, Last)  2. Date of Death 2. Time of Death 3. Time of Death
Physicia Medic		CHARLES ALONZO KING Worth Day 2010 4 A M
Examin		a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death  ACCOUNTY OF DEATH  ACCOUNTY OF DEATH
Funeral Director		Figure   Graduate
laryland 8a-f show ified at	ector	Sual Residence of Decedent
with the M 23a or 20 ust be no	Funeral Director	MO FREDERICK FREDERICK  De. Street and Number  244 EAST PATRICT ST  10f. Zip Code 21101  10g. Citizen of What Country?  USA  10g. Citizen of What Country?  USA
0	þ	1. Marital Status 1. Marital Status 1. Marital Status 1. Never Married 2. Married 3. Widowed 4. Divorced 1. Divorced 1. Marital Status 1. Was Decedent Ever in U.S. Armed-Forces? 1. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Yes or No-If Yes, S
altimore, Maryland 21215-0036 mit. Page 1 and 2 should be filed within 72 hours after partners of Health and Mertal Hygiens portant if item 27 is marked other than "natural", o y injury or other traumatic event, the Medical Examos.	e Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  PRIVITE  16b. Kind of Business Industry  OLS ABLES
yland  Jack be filed  I Mental H  narked ot  natic even	To Be	7. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)  ESUN R. Brown
Mar nd 2 shou leatth and m 27 is n her traum		9a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  SOON, HARRY S, TRYMAN DY # 320 CAR60 MD.
Baltimore permit. Page 1 a Department of I- Important: If ite any injury or ott		Da. Method of Disposition  1
Balt permit. Depart Import any inj		1. Signature of Funeral Service License  Willy CX. Follows  22. Name and Address of Facility GARY L. ROLLINS FOW. Hom E  110 WCST SOUTH ST PHILDERIUM MO LITOI
Physician/ Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate
Examiner	er	mmediate Cause (Final lisease or condition esulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):
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		d
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	FEMALE:  23c. If yes, outcome of pregnancy in the past 12 months?  1
ords, P.O. Borredures that the debeen signed by the should be detached	<u>ا ۾</u>	art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown
/ital Record sician: The law req certificate has bee lirector, page 2 shou	Completed	24a. Was an autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No
Cal Fian: T ian: T		5. Was case referred to medical examiner?  26. Place of Death (Check only one)
Vit hysic his ce I direc	욘	Hospital:  1   Yes   2-  No
ion of ending P eath. or: After tl	Certificate:	7. Manner of eath 1
Division of Vital ppital or Attending Physician: ours after death. neral Director, After this certific filled in by the funeral director,		4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hospital within 24 hours a To the Funeral L completed filled	Medical	9a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<b>₽</b> ₹ ₽ 0		29c. License number 29d. Date signed (Month, Day, Year)  10/14/10
CR 10		D. Name and address of person who completed cause of death (Item 23a) (Type, Print)  D. MK M DUMA C502 KENILWONDS AVE / LIVER 03-LB MD 2-7-2-7
Stat Registra	~	DCT 1 4 2010 Security 32. Registrar's Stinatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle | ast) Month / C Physician/ BIBU . Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) HOUSE 4b. City, Town, or Location of Death Examiner MONTGOMERY HOSPIC CASEY 1 Year If Under 24 Hrs.
Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, GHANISTAN Director Usual Residence of Decedent 10d. Inside City Limits or items 23a or 28a-f show th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a, State 10b County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 No BURTONSVILL MD MONTGOMERY 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number Funeral 208 AFGHANISTAN Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11, Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) DIPLOMA DIPLOMATIC SER. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Page 1 and 2 should be fi ment of Health and Menta ant: If item 27 is marked KHAIR MOHAMMAD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 🗥 🕜 19a. Informant's Name/Relationship (Type, Print) R. BURTONSVILLE MD HAMEED KARZAT other i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of H Important: If ite any injury or oth Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/09/10 21. Signature of Euneral Service Licensee 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirate shock, or heart failure. Just only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final Rulmonary +h sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Physician: The law requires that the death certificate be executed ending physician and use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death
Unknown ₫ 2 No the 9 Unknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 has page certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) **Division of Vital** 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ER/Outpatient 3 DOA Certificate: To 1 Inpatient 2 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending work? 1 ☐ Yes 2 ☐ No 5 Pending Natural Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0060634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BINDU JOSEPH MD · 6001 MUNC 6001 MUNCASTER MILL RD. ROCKVILLE MD. 20855

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Pauline E. Kegley October 21, 2010 9:00 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick College View Center Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth July 1, 1 🗆 M 2 🗶 F 1926 Director 220-28-8338 84 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Frederick Thurmont Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21788 United States 10530 Hessong Bridge Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian or i Armed Forces Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White should be filed within 72 hours aft and Mental Hygiene. 'is marked other than "natural", 3 X Widowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 (Unknown) Eichelberger Lula Belle (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Gary Keeney / Son 10530 Hessong Bridge Road, Thurmont, Maryland 21788 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State October 23. 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) St. Paul's Cemetery 2010 Jefferson, Maryland 21. Signature of Funeral Service Licenses Keeney and Bastord PA Funeral Home 106 E. Church St. M01473 Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician, ementro disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause [Disease or imjury] Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transii that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Year Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performa 2 🗌 No Yes 2 N Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗌 Yes မူ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tyes 2  $\square$  No 'Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10-21-2010 D604

7 DHMH 17 Rev 7/2009

JK

State Registrar Thomas

32. Registra s Signature

Frederick

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2271 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 8, 2010 Year Physician/ LOUBE 3:35 Рм Nathan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Silver Spring **Examiner** 4c. County of Death 10104 Dallas Ave. Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 88 yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 0ct. 27, Year 921 1 🕅 M 2 🗆 F Washington, DC 578-12-4924 Director Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural". 10a. State 10b. County 10c. City, Town or Location Silver Spring 10d. Inside City Limits Director Montgomery Md. 1 🗆 Yes 2 💢 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 20901 <u>10104 Dallas Ave</u> Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces? Black, White, etc. White þ 1 Never Married 2 Married If Yes, Give Year or Dates. WWII 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Promotions Self-employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ida Yerosefsky Sonia Loube Abraham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1226 Cavendish Dr., Silver Spring, Md. 20905 19a. Informant's Name/Relationship (Type, Print) Ruth Oliver / daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State cemetery, crematory or other place) King David Mem. Garden Oct. 10, 2010 Falls Church, Va. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 21. Signature of Funeral Service Licenses 254 Carroll St., N.W., Washington, D.C. 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 3 months Metastatic Lung Cancer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live Birth Z L 1 can L Pregnant at time of death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year signed by the a d be detached f g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Chronic Bronchiectasis 1 ☐ Yes 2 ☐ Yoo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an

The law requires that the death certificate be executed Box 68760 P.O. Records, cate has been sig certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I **Division of Vital** 

Completed autopsy performed? Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 📉 No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: work?
1 Yes 1 X Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Oct. 8, 2010 10+1 D35996

State Registrar end

LInda M. Burrell, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Linda M. Burrell, MD 2730 University Blvd., W #400, Wheaton, Md. 20902

Funera Directo

	1 - State Registrar			Cer	tificate of	Death	Reg	j. No. 🤈 [	110	2271
an/	1. Decedent's Name (First, Middle, Las	st)					Date of Death     Month	Dav	Year	3. Time of Death
an/ cal		Jane Lev	vin_				October	09, 2	0 1 0	10:58 p
ner	4a. Facility Name (if not institution, give					or Location of Death		4c. County		
	Atrium Vi					ings Mills If Under 24 Hrs.				timore
	5. Social Security Number 6. S	ex ☐ M 2 <b>X</b> ☐ F	e (in yrs. ias 86	st birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Ye 12/31/19	ar) 2	9. Birth	olace (State or Forei Maryland
	217-14-2336 Usual Residence of Decedent		80				12/31/19	23		into corcorto
ğ	10a. State 10b. County		10c. City,	Town or Loc	ation				1	I0d. Inside City Limi
Director	Maryland Bal	timore			(	Wings Mil	ls			1 🗌 Yes 2 🛣
								g. Citizen of		
Funeral	4730 Atrium			21117			u.s.	Α		
		Ever in U.S.			Hispanic Origin? (Special)			ce - Americ		
<u>a</u>		No	1	☐ Yes 2 🗓 N	o Specify:		Specify			
etec	3 X Widowed 4 Divorced	Year or Dates.		16a Doord	ont's Heural Occur	nation	14			
Completed	(Specify only highest gra	ade completed)	(Give k	icedent's Usual Occupation ive kind of work done during most of working i, DO NOT use retired)			3b. Kind of B	ousiness in	dustry	
្រី	Elementary/Seconday (0-12)	Elementary/Seconday (0-12) College (1-4 or 5+)				Specialist	. 1	edera	l Goi	vernment
æ			18. Mother's Name (First, Middle, Maiden Surname)				re)			
₽	Samu	Elizabeth Cohen								
	19a. Informant's Name/Relationship (T	ype, Print)		19b. Mailin	g Address (Stree	t and Number or Rura	al Route Number, C	er, City or Town, State, Zip Code)		
	Jack Schwartz -	Nephew		7012	Tilden I	Lane, Rock	ville, Ma	vrylan	d 208	352
	20a. Method of Disposition		20b. Pla	ace of Dispos	sition (Name of	ace)	Date 20	c. Location	- City or To	own, State
	1 1 Burial 2 Cremation 3 Removal from State Hebriew Genetary or other place) 4 Donation 5 Other (Specify)  21. Signature of Furtheral Symptoc Libertsee)  22. Name and Address of Facility Hines-Rinaldi Function								ore, 1	Maryland
	21. Signature of Funeral Service Licens	ee		22	Name and Addr	ess of Facility Hiv				
上	Chicker, 1. No.	rua Moiz	241	111	800 New	Hampshire	Ave., Si	lver S	Sprin	g, MV 209
	23a. Part 1. Enter the disease, or com shock, or heart failure. List only o			. Do not ente	r the mode of dy	ing, such as cardiac	or respiratory arrest			Approximate Interval Between
	Immediate Cause (Final disease or condition	Va	scu	lan	Dem	entier				Onset and Death
	resulting in death)	Due to (or as a	a conseque	ence of):						
_	Sequentially list conditions,	b								
Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a	ence of):							
xan	Cause (Disease or iinjury that initiated events	C. Due to for as	a conseque	ence off:					-	
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sician/Medical	IF FEMALE:	23c. If yes, outcome	of pregnan	icy				23d D	ate of deliv	en/
ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live Birth 4 ☐ Pregnant a			Ectopic pregnal Other (specify)	ncy		23d. Date of delivery  Month Day Year		
Physi	9 Unknown	9 🗌 Unknown								
by Pl	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use							cco use con	tribute to tl	he cause of death?
							1 🗆 Yes	2 🗌 No	3 🗌 Pro	bably 4 Unkno
olete							24a. Was an	24b.	Were auto	psy findings availab
Completed							autopsy performe	d?_	death?	mpletion of cause o
ø	25. Was case referred to medical				26.	Place of Death (Chec		Z NO]	i Li Yes	Z LI NO
10 B	examiner?	Hospital:	ient 2 $\square$ F	ER/Outpatien	_ Ot	hor	ome 5 🗆 Residence	ce 6 X Oth	ner (Specifi	Assiste
	27. Manner of Death	28a. Date of inju	iry :	28b. Time of injury	28c. Inju	ıry at	28d. Describe how			, 2.00.01.0
Φ										
icate	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigation		y, rear)	mjury		Yes 2 No				
ertificate:	1 Matural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	n 290 Place of Init	ury - At hon	ne, farm, stre	M 1	Yes 2 □ No	28f. Location (Stree City or Town, S		per or Rura	l Route Number,

State

Medical

29a. Certifier (Check

31. Date filed

29b. Signature and title of certifier

OCT 1 2 2010

Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tehseen R. 28 35 Smith Avenu, Suit 203,

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

006

29d. Date signed (Month, Day, Year)

10

Nagvi, M.D.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	To To Con		> Tel late	el Jananti		Dog	52586		10/10/10			
			29b. Signature and title of certifier			29c. License	e number	290	I. Date signed (Month,	Dav. Year)		
	the Hospi nin 24 hou the Funer npleted fill	Medical	(Check 2 Medical Exami only one) 3 Certifying Nurs	sician: To the best of my kn ner: On the basis of examina ee Practioner: To the best o	ation and/or inves	stigation, in my opinio death occurred at the	on, death occurred at e time, date and plac	t the time, date and pose, and due to the ca	place, and due to the ca luse(s) and manner as st	use(s) and manner stated, ated.		
Division of Vital Records,	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completed filled in by the fune	al Certificate:	3 Suicide 6 Could not be 4 Homicide determined					28f. Location (Stree City or Town, \$	et and Number or Rura State)	l Route Number,		
n of ∖	Tel 19		27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year	28b. Time o	f 28c. Injury work	y at	ome 5 ∐ Residence 28d. Describe how		7		
/ita	/sicial	To Be	evaminer?	Hospital:	☐ ER/Outpatio	Othe	er:		ce 6 🗆 Other (Specify	· · · · · · · · · · · · · · · · · · ·		
l Rec	ysician; The law is certificate has director, page 2		25. Was case referred to medical			26 DI	and of Death (Charl	performe 1 \(\sum \) Yes 2	ed? death?			
Sords	aw require as been si 2 should	Completed						24a. Was an autopsy	24b. Were auto	psy findings available impletion of cause of		
s, P.O.	res that t signed b f be deta	by	Part II. Other significant conditions co	ontributing to death but not	resulting in the I	underlying cause giv	ven in Part I.		cco use contribute to the	ne cause of death?		
Box 68	Physician; The law requires that the death certific, this certificate has been signed by the attending fral director, page 2 should be detached for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 █ No 9 ☐ Unknown	23c. If yes, outcome of pre 1  Live Birth 2  I 4  Pregnant at time 9  Unknown	etal death 3	☐ Ectopic pregnand☐ Other (specify)	су		23d. Date of delivery Month Day Ye			
092	icate be executed physician and s the burial-transit	edical Exa	Chalse (Disease of Iniquity that initiated events resulting in death) Last	c. Due to (or as a cons	sequence of):							
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Et let Underlying Cause (Disease or linjury	b. Due to (or as a consequence of):								
	Pnysician/ Medical Examiner	0 00	disease or condition resulting in death)	a. Due to (or as a cons		atic Lung	Cancer	_				
	Device to total a		23a. Part 1. Enjer the disease, or comp shock, or neart failure. List only or Immediate Cause (Final	plications that caused the done cause on each line.		er the mode of dyin	g, such as cardiac c			Approximate Interval Between Onset and Death		
Balt	permit. Depart Import any inj once.		21. Signature of Fund 1 Service Licens	Pauler TR. CE	25 25 A	2. Name and Addres Mo 26401	ss of Facility lesworth- Ridge Roa	Williams	, P.A., Furcus, Maryl	neral Home and 20872		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	b. Place of Dispo cemetery, cre Metro Cremat	osition (Name of matory or other plac Opolitan orium_In	c. Oct.1		Oc. Location - City or To lexandria,			
, <b>Μ</b>	and 2 st lealth a sm 27 is her trau		Laurene NMN Levy	/ Daughter	2481	6 Sweet C	herry Lar	ne, Damas	cus, MD 20	872		
aryla	nd Men s marke smarke	-	James 19a. Informant's Name/Relationship (Ty	Vasilion (pe, Print)	19b. Maili	ng Address (Street 2		elen Mang	laras ity or Town, State, Zip (	Code)		
nd 2	e filed w tal Hygi d other event, t	കി	17. Father's Name (First, Middle, Last)		1	nome	18. Mother's Name	Aker Own Home  Mother's Name (First, Middle, Maiden Surname)				
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စ္အ	ter deati , or item miner n	by Fur	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No		Was Decedent of Hi	an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,			
	is 23a o	Funeral	24816 Sweet Cherr	y Lane		101. 215 0000	20872		U.S.	•		
	ne Mary or 28a-1 notifie	Director	Maryland Montgom	ery		Dam	ascus	10	g. Citizen of What Cou	1 Yes 2 No		
	rland f show d at	tor	Usual Residence of Decedent  10a. State  10b. County	10c.	City, Town or Lo	ocation				10d, Inside City Limits		
b	Funeral Director		331-26-5555	M 2 DF	6 Yrs.	Months Days	Hours Min.	(Month, Day, You April 13	cour	inois		
١	/		Holy Cross Hospit  5. Social Security Number 6. Se		rs. last birthday)	Sil If Under 1 Year	ver Sprin	1g 8. Date of Birth	Montgo	mery place (State or Foreign		
-	Medic Examin	al	4a. Facility Name (if not institution, give	NMN Levy street and number)	r Location of Death	October	4c. County of Death	8:30 A M				
ı	Physicia	n/	1. Decedent's Name (First, Middle, Las					2. Date of Death Month October	10, 2010	3. Time of Death		
			State Registrar		Cei	rtificate of L	Death	Reg	. No. 9 0 1 0	00710		

DHMH 17 Rev 7/2009

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** William 5:50 AM Lech lider 10 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Center Spring Layhill Silvar imo long If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 26 9. Birthplace (State of oreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 10M 20F Months Days Hours Min. 212-96-9404 65 Jan. Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show or than "natural", or items 23a or 28a-f sho Md. Montgomery Gaithersburg 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23220 Laytonsville Road 20882 by Funeral United States within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married White 1 ☐ Yes 2 ▼No Specify: Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Farmhand Family Farm permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other any Injury or other traumatic event, It 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be George E. Lechlider Sara Cunningham ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 23220 Laytonsville Road, Gaithersburg, Md. 20882 Nancy L. Hitchcock / Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Laytonsville Cem. 10/13/10 Laytonsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licensee Xo 20882 P. O. Box 5038, Laytonsville, Md. 23a. Part 1. Enter Me disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Posterior Immediate Cause (Final disease or condition resulting in death) **Physician** 11/2003 /Medical Posterior Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transi Vantal Retardatio and Due to (or as a consequence of): physician Physician/Medical the attending p for use as as IF FEMALE: If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day been signed by the should be detached Š Completed icate has b page 2 sl certificate After this certific funeral director, Be Certification: To

law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Baltimore, Maryland 21215-0036

1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown
Part II. Other significant condition	ntributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death  1   Yes 2   4   0   3   Probably 4   Unknown
	24a. Was an autopsy performed?   24b. Were autopsy findings availar prior to completion of cause death?   1 \[ Yes \] 2 \[ No \]
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	26. Place of Death (Check only one)  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
27. Manne of Death 1	28a. Date of Injury (Month, Day, Year)  28b. Time of Injury  28c. Injury at Work?  M 1   Yes 2   No
3 Suicide 6 Could no determin	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a Certifier 1 Certifying	reician: To the best of my knowledge death occurred at the time date and place and due to the cause(s) and manner as stated

Medical

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

H67624

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 29c. License number

10/11/10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bal Pre Rd. 3227 5 ilves

Sultana J. Afrooz, M.D. Spring 20906

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 32. Registrar's Signature OCT Charrie

D. 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4<sup>Day</sup> Physician/ OCT Th 20°1°0 ANN LEE 1922 SHIRLEY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Chever<u>ly</u> Prince Georges Hospital If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** (Month, Day, Year) pr 12, 1941 Months 1 □ M 2 🛣 F Days Hours Min. Country) Yrs DC Director 69 Apr 220-32-1574 Usual Residence of Deceden 28a-f shov 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location notified at Director MD Prince Georges Largo 1 Yes 2 X No 10f. Zip Code ö 10e. Street and Number 10g. Citizen of What Country? ms 23a or Funeral USA 906 Peconic P1. 20774 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, ural", or iter Black, White, etc. þ 1 Never Married 2 X Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black "natural" Completed 3 Widowed 4 Divorced Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical! 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Assoc. of Flight Attend. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Annie Brunson Samuel Harper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 906 Peconic Pl. Largo, MD. 20774 Clarence E. Lee - Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1:
Department of I
Important: If its
any injury or of 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Veterans Cemetery 10-14-2010 Cheltenham, MD Signature of Funeral Service Licenses Marshalld Maryland Suitlnad, MD. 20746 4308 Suitland Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ Cardiac Arrythmia Medical Due to (or as a consequence of): Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence on attending physician and for use as the burial-transit Cause (Disease or linjury HIstory of Lung Cancer that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hisotry of Brain Cancer certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ for in the past 12 months? Month Day Year ed by the a 9 Unknown 9 Unknown P.O. cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No Yes 2 X No 1 Tes Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 XNo ၉ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 😾 ER/Outpatient 3 ☐ DOA filled in by the funeral 28b. Time of 28c. Injury at s after death. I Director: After the 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred Certificate: 1 XNatural 5  $\square$  Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) the within To the 29b. Signature and title of certify 29d. Date signed (Month, Day, Year)

State Registrar 3001 Hospital Dr.

32, Registra Signa

Cheverly, MD 20785

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cumberbatch, MD

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month OCT 18 2010 Physician/ EARTHA LORENE LIPKINS 6:45 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY NATIONAL NAVAL MEDICAL CENTER BETHESDA 8. Date of Birth (Month, Day, Year) Oct. 27.1 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 M 2 XF Min. Months Hours **Director** Florida 264-44-9808 Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Director 1 Yes 2 No DC Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 20032 United States 328 Raleigh Street, SE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 ₩ Widowed 4 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Government Supervisor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည William Stanford Elmira Belton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 323 West Ellis Avenue Cheryl Moxley/daughter

Physician/ Medical Examiner

Box 68760

Division of Vital Records, P.O.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the bunal-transit

	20a. Method of Disposition		Place of Disposition (Nemetery, crematory of	ame of	1/15/10	20c. Location - City of	or Town, State
	1 Surial 2 Cremation 3 Repair (Specify)	emoval nom State				Arlingto	on. VA
	21. Sonatule of Funeral Service Licensee					& Edwards	
j /	Januar En	wands				Suitland	
	23a/ Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final	cause on each line.	th. Do not enter the me	ode of dying, such as			Approximate Interval Between Onset and Death
	disease or condition resulting in death)	Due to (or as a consequ	ARY ARTERY uence of):	DISEASE			
miner	Sequentially list conditions, if any, leading to immediate cause. Enter the entrying Cause (Disease or iinjury	Due to (or as a consequence)					
sal Exa	that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):				
edic	d						
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2¾☐ No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Fett 4 ☐ Pregnant at time of g ☐ Unknown	al death 3 Dectop			23d. Date of d Month	lelivery Day Year
F.	Part II. Other significant conditions con	tributing to death but not re-	sulting in the underlyin	g cause given in Part	1. 23e. Did	tobacco use contribute	to the cause of death?
ed by					1 🗆	Yes 2 No 3	Probably 4 - Unknown
complete					per	opsy prior to formed? death?	autopsy findings available o completion of cause of es 2 No
BeC	25. Was case referred to medical			26. Place of Dea	th (Check only one)		
0 B	examiner? 1 Yes 2 No	ospital: 1 ፟፟፟፟፟ Inpatient 2 □	BR/Outpatient 3 🗆	DOA Other: 4 🗆 Ni	ursing Home 5 🗆 Res	sidence 6 Other (Spe	ecify)
icate: 1	27. Manner of Death  1 🐷 Natural 5 🗌 Pending 2 🗋 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? 1  Yes 2		how injury occurred	
Certif	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, street, fact	ory, office		(Street and Number or Fown, State)	Rural Route Number,
Medical Certificate: To	(Check - 2 Medical Examine	cian: To the best of my know er: On the basis of examination Practioner: To the best of m	on and/or investigation.	in my opinion, death or	ccurred at the time, date	and place, and due to the	e cause(s) and manner state
-	29b. Signature and title of certifier	1		29c. License number		29d. Date signed (Mor	nth, Day, Year)
	X CUIN S	E MP	.	D-63995		10/20/10	

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

OHMH 17 Rev 7/2009

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LCDR

ASLAM

SAIRA N.

31. Date filed (Month, Day, Year)

MC

USN

32 Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar  State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No. 2010 33753											753		
Physicia	n/	1. Decedent's Name (First, Middle							Date of De     Month		Year	3. Time of	
Medic	al	James Shern 4a. Facility Name (if not institution,				Ab City To	um or loop	ation of Death	Octobe		2010 nty of Death	11:55	<b>A</b> M
Examin	er	Glade Valley Nursi	-	inger)			kersvi.				rederic		
Funeral Director		5. Social Security Number <b>025–20–8210</b>	6. Sex 1 <b>X</b> M 2 □ F	_	yrs. last birthday) Yrs.	If Under 1 Months D		Jnder 24 Hrs. ours Min.	8. Date of Bir Month, Da <b>February</b>	th (18, 1926	9. Birth Cou <b>Mass</b> :	nplace (State or ntry) <b>achusetts</b>	Foreign
ld how	_	Usual Residence of Decedent  10a. State 10b. County		10	c. City, Town or Lo	cation						10d. Inside City	v Limits
larylar <b>3a-f st</b> ified a	ecto		derick		,,		derick					1 🗆 Yes	1
a or 28	ä	10e. Street and Number			_	10f. Zip Co				10g. Citizen		-	
th with ms 23 must	Funeral Director	8102 Broadview Driv					21701		'6 N N-			of Americ	:a
DESILITIOF BY INTERPLIATION Z I Z I 3-00.30 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 <b>X</b> Marr</li><li>3 ☐ Widowed 4 ☐ Divorced</li></ul>	If Voc. G	orces? 2 X No ive		was Decedent f Yes, specify	Cuban, Me	exican, Puerto	cify Yes or No- Rican, etc.)	No-  14. Race - American Indian, Black, White, etc.  Specify: White			
2-UUSO 2 hours afte "natural", c	plet	15. Deceder (Specify only highe	nt's Education st grade completed	d)	(Give		one during	most of worki	ing	16b. Kind o		•	
ithin 7 ene. r than	Completed	Elementary/Seconday (0-12)		1-4 or 5+)		ONOTuserei : Mail Ad	,	sino			lishin	Research g	
filed w all Hygi	Be	17. Father's Name (First, Middle, L	.ast)	-	22200				e (First, Middle,	Maiden Surna	me)		
yland Ild be filed Mental Hy narked oth	၀	James Woodward Mo			_			Leora Lo	ouise Edv	vards			
, Wilding 18 shot salth and 27 is ner traum	15	19a. Informant's Name/Relationsh  Amanda McGreeby /							l Route Numbe derick, N			Code)	
JOTC, ge 1 and nt of Hear or other		20a. Method of Disposition  1  Burial 2  Cremation			20b. Place of Dispo cemetery, crei	natory or othe	r place)	Octo	per 26, 10	20c. Locatio	•		
Dalling	9	4 Donation 5 Other (S	pecify)		Smithsbur						burg,	Maryland	
permii Depar Impol any in		1		M	01433	eeney & 06 East	Basfor Church	rd P.A. I h Street,	uneral H	lome ick, Mary	land 2	1701	
Physician/ / Medical		23a. Part 1. Enter the disease, or shock, or heart failure. List o immediate Cause (Final disease or condition resulting in death)	only one cause on e	ach line.	SEAH Y		f dying, suc	ch as cardiac o		rrest,		Approximate Interval Betw Onset and D	/een
Examiner			Due to	(or as a co	quence of):								
_ +	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	b. Due to	(or as a co	nsequence of):								
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be exessician sician	dical Examiner	roodking in dodaily East	d	(=- === ====									
ificate b		IF FEMALE:	_ u:					-					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown		eBirth 2. ☐ gnantattim	Fetal death 3	Ectopic pred Other (speci	gnancy fy)				Date of deli Month	,	əar
that the ned by e deta	oy Pi	Part II. Other significant condition	ons contributing to	death but n	ot resulting in the u	ınderlying cau	se given in	Part I.	23e. Did t	obacco use co	ontribute to	the cause of de	ath?
quires quires en sig	ted	- Hypertensic	n.						1 🗆	Yes 2 N	3 🗆 Pro	obably 4 🗆 U	nknown
The law requires ate has been signage 2 should be	Somple								24a. Was auto perfo 1 \(\sum \) Yes		prior to co death?	opsy findings avompletion of ca	/ailable use of
ysician: ysician: s certific	Be	25. Was case referred to medical examiner?	Hospital:					of Death (Check	only one)				
Phys Phys r this eral dir	e: 10	1 ☐ Yes 2 📉 No 27. Manner of Death	28a. Date	of injury	2 ER/Outpatie		Other: 4 J Injury at		me 5 Resi			fy)	
ath.	icate	1 ☒ Natural 5 ☐ Pendin 2 ☐ AccidentInvestig	g (Mo	nth, Day, Ye	ear) injury	- 1	work? 1  Yes		200, 2000, 150	now injury coo			
al or Attending P a safter death. I Director: After t d in by the funera	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	inod 28e. Plac	e of Injury - ling, etc. (S	At home, farm, str pecify)	eet, factory, of	fice		28f. Location ( City or Tov		nber or Rura	al Route Numbe	эг,
e Hospit 24 hour e Funera leted fille	Medical	(Cheph 2 D Medical E	Physician: To the examiner: On the banks	sis of exam	ination and/or inves	tigation, in my	opinion, dea	ath occurred at	the time, date a	and place, and	due to the ca	ause(s) and man	ner stated.
To th withir To th	~	29b. Signature and title of certifier	^	, 01		29c. Li	cense num	nber		29d. Date sig	ned (Month,		
15		30. Name and address of person	who completed cau		(Item 23a) (Type, I	Print)		(3 deng	1		, -		
,		31. Date filed (Month, Day, Year)	0 mc 3	Registrar's	Signature	<b>Y</b>	PRE	deng.	K ME	) ~1 <sup>2</sup>	02		
Stat Registra		OCT 27 2010	Beneva	A	Signature								

Division of Vital Records, P.O. Box 68760
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director. After this certificate has been signed by the attending physician and

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State of Maryland / Department of Health and Mental Hygiene																	
		For State Registrar		5	itate of	ı ıvıaryı	anu /	•		e of E		and iv	ientai Hy		e 10. ^ _		0.0 ===================================	
Physicia Medic		1. Decedent's Name Isabel	e (First, Middle	, Last)	Mei	njiva	ar		Meji	La			2. Date of D	eath	40	Year	3:Time of Death	
Examin		4a. Facility Name (if 23 Shad									Location o			4		of Death	ery	
Funeral Director		5. Social Security Nu 217-53-2	2101	6. Sex 1 💆 M	2 🗆 F	7. Age (In y		irthday) Yrs.	If Unde Months	r 1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of B		34	9. Birthplace (State or Foreign Equingal Vador		ign <b>r</b>
aryland a-f show fied at	ector	Usual Residence of 10a. State MD	10b. County Monto	gomei	-Y	10c.	City, To	wn or Loc	rsbu	ırg						10	0d. Inside City Lim	
with the Mi 23a or 28 ist be noti	Funeral Director	10e. Street and Num 23 Shad	dy Spi	ring	Plac	ce			10f. Zij	20 <sup>code</sup> 208	77					What Country?		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status  1  Never Marri 3  Widowed		ried .	Armed Ford	2 🔁 No	ı U.S.	13. W If	Yes, spe	cify Cuba	spanic Orig n, Mexican, Specify: Vado	, Puerto	cify Yes or No Rican, etc.)	-		ce - American Indian, ack, White, etc.		
within 72 hour giene. er than "natul the Medical	Completed	(Spec	15. Deceder cify only highe onday (0-12)	st grade co		4 or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Farmer							16b. l		usiness Ind		
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nd 2 shouic salth and N n 27 is ma er trauma		19a. Informant's Na Evelin	me/Relationsh Menjiv	ip (Type, P Jar/I	Daugl												Md2087	
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permit. Departi Import any inj	20a. Method of Disposition   20b. Place of Disposition (Name of Sam Agusti San Agusti Utan, El Salvador   10/16/2010   20c. Location - City or To San Agusti Utan, El Salvador   10/16/2010   20c. Location - City or To San Agusti Utan, El Salvador   10/16/2010   20c. Location - City or To San Agusti Utan, El Salvador   10/16/2010   20c. Location - City or To San Agusti Utan, El Salvador   10/16/2010   20c. Location - City or To San Agusti Utan, El Salvador   10/16/2010   20c. Location - City or To San Agusti Utan, El Salvador   10/16/2010   20c. Location - City or To San Agusti Utan, El Salvador   20c. Location - City or To San Agusti Utan, El Salvador   20c. Location - City or To San Agusti Utan, El Salvador   20c. Location - City or To San Agusti Utan, El Salvador   20c. Location - City or To San Agusti Utan, El Salvador   20c. Location - City or To San Agusti Utan, El Salvador   20c. Location - City or To San Agusti Utan, El Salvador   20c. Location - City or To San Agusti Utan, El Salvador   20c. Location - City or To San Agusti Utan, El Salvador   20c. Location - City or To San Agusti Utan, El Salvador   20c. Location - City or To San Agusti												,P.A.					
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requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent   in the past 12 n 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?	1	Live B	ome of pre lirth 2  ll ant at time own	Fetal dea		Ectopic   Other (sp	pregnancy pec <i>ify)</i>	у					te of deliver	y Day Year	ì
ires that th signed by d be detac	þ	Part II. Other signifi	icant conditio	ns contrib	uting to de	ath but not	resulting	g in the ur	nderlying	cause give	en in Part I.						e cause of death?	own
The law require cate has been si page 2 should b	Completed					_							24a. Was auto perf 1 🔲 Yes				sy findings availab apletion of cause o	
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nding Phy ath. r: After thi e funeral d		27. Manner of Death 1  Natural 2  Accident	5 Pendin	g	8a. Date o		28b.	. Time of injury		8c. Injury work?	at	2	28d. Describe					
To the Hospital or Attending Physician: The law within 24 Hours after death.  To the Funeral Director. After this certificate has I completed filled in by the funeral director, page 2 s	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could in determ		8e. Place o buildin	of Injury - A g, etc. (Spe	t home, t	farm, stree	et, factor	, office		1	28f. Location ( City or To			er or Rural F	Route Number,	
he Hospit in 24 hour he Funera ipleted filla	Medical	(Check 2	Certifying  Medical E  Certifying	xaminer: "	on the basis	s of examina	ation and	/or investi	gation, in	my opinio	n, death occ	curred at	the time, date	and place	<ul><li>e, and due</li></ul>	e to the caus	se(s) and manner st	tated.
To t with com		29b. Signature and t	itle of certifier	Λl	1	-	N	1	290	165						11,20		
Τ'		30. Name and addre Andre								Sui Stre	te 2 eet N	208B IE W	ashin	gto	n,D.	C.		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar  Certificate of Death Reg. No. 2 0 1 0 2 2 7 5 5										
			Registrar  1. Decedent's Name (First, Middle, Last)		incare or b	<u>Catri</u>	2. Date of De		3. Time of Death			
	Physicia Medic		Doris Marie Louise Matchett				Octobe	er 7,2010 Ye	9:30A. M			
	Examin	er	4a. Facility Name (if not institution, give street and number) 17800 Howe Drive		4b. City, Town, or	Location of Death		4c. County of D				
-3	Funeral		5. Social Security Number 6. Sex 7. Age (I	'In yrs. last birthday)	Olney If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	Montgom	ery Birthplace (State or Foreign			
×	Director		142–30–1569 1 □ M 2 <b>X</b> □ F	71 Yrs.	Months Days	Hours Min.	NOV .	v. Year)	Country) <b>ew Jersey</b>			
	nd <b>how</b> at	'n	Usual Residence of Decedent           10a. State         10b. County         1	10c. City, Town or Loc	ation				10d. Inside City Limits			
	Maryla 18a-f s tiffied	Director	MD Montgomery	Olney					1 <b>□k</b> √es 2 □ No			
	h the l 3a or 2 be no	a Di	10e. Street and Number		10f. Zip Code			10g. Citizen of What	*			
	ath wit	Funeral	17800 Howe Drive  11. Marital Status 12. Was Decedent Eve	arin IIS 13 M	20832 Vas Decedent of His	enanic Origin? (Sp.	acify Yes or No.	United St				
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	5	1 ☐ Never Married 2 ☐ Married Armed Forces?  1 ☐ Never Married 2 ☐ Married ☐ 1 ☐ Yes 2 ☑ No.  3 ☐ Widowed 4 ☑ Divorced Year or Dates.	lf .	Yes, specify Cuban  Yes 2 X No	, Mexican, Puerto	Rican, etc.)		merican Indian, /hite, etc. hite			
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/lan	d be fil //ental arked rtic ev	욘	Carl Herman Fieks			Mathilo		eler				
<b>Nan</b>	should and h		19a. Informant's Name/Relationship (Type, Print)	1				r, City or Town, State,	Zip Code)			
e, l	and 2 Health tem 2;		Shirley Edwards/Friend  20a. Method of Disposition	765 I 20b. Place of Dispos	Lalton Dr.	! "		9526 20c. Location - City	or Town State			
imor	Page 1 ment of tant: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify)	Geo. Wash Medical C	i.Universi Lenter	ty Octob		Washingto	n,D.C.			
	Depart Impor any in		21. Signature of Funeral Service Licensee /N	Nortuary S n,MD 20706	ervices,P.A.							
			23a. Part 1. Enter the disease, or complications that caused th shock, or heart failure. List only one cause on each line.	e death. Do not enter	r the mode of dying	, such as cardiac	or respiratory ar	rest,	Approximate Interval Between			
	Pnysician/ Medical		Immediate Cause (Final disease or condition resulting in death)  a. Cancer of the condition can be a condition and the condition can be a condition and the condition and the condition can be a condition and the	of the Lung	g with Me	tastases			Onset and Death			
	Examiner			onsequence on.								
	d sit d	dical Examiner	Sequentially list conditions, if any, leading to immediate outce. Enter Underthing Cause (Disease or iinjury	onsequence of):								
	ecute and Il-trans	Exar	Cause (Disease or injury that initiated events c. Due to (or as a coresulting in death) Last Due to (or as a coresulting in death) Last	onsequence of):								
09	s be ey sician s buria	ical	d									
876	tificate ng phy as th	Med	IF FEMALE:									
9 xc	ath cer attendi for use	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	🗌 Fetal death 3 🔲	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year			
Ö.	the dea	hysi	1 ☐ Yes 2 🔀 No 4 ☐ Fregnant at til 9 ☐ Unknown 9 ☐ Unknown	nie or death 3 🗀	Other (specify)	1						
P.	s that i	by P	Part II. Other significant conditions contributing to death but	not resulting in the un	nderlying cause give	en in Part I.	23e. Did to	obacco use contribute	e to the cause of death?			
rds,	equire een si	eted							Probably 4X Unknown			
Division of Vital Records, P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed					24a. Was autor perfo 1 \subseteq Yes	osy prior rmed? death	autopsy findings available to completion of cause of 1? Yes 2  No			
ta	cian: 1 ertifica ector, p	Be	25. Was case referred to medical examiner?			ce of Death (Checi		2, 10	103 2 110			
Ž	Physi this craftire	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 27. Manner of Death 28a. Date of injury	2 ER/Outpatient	3 DOA Other	_4 ☐ Nursing Ho		lence 6 Other (Sp ow injury occurred	pecify)			
o uc	nding ath. r: After	icate	1 ☑ Natural 5 ☐ Pending (Month, Day, You 2 ☐ Accident Investigation	'ear) injury	work?		zod. Describe n	ow injury occurred				
ivisio	or Atte after de Directo in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc. (\$	- At home, farm, stree Specify)	et, factory, office		28f. Location (S City or Tow	itreet and Number or n, State)	Rural Route Number,			
Ω	pspital hours neral d filled	edical	29a. Certifier 1 Certifying Physician: To the best of my	knowledge, death or	ccured at the time, o	date and place, an	d due to the car	use(s) and manner as	stated.			
	the Hothin 24 the Fu	Med	(Check 2 Medical Examiner: On the basis of exam	nination and/or investion in the state of th	aith bodumed at the	time, date and plac	e, and due to the	couss(s) or dimer not	as statud			
	_		29b. Signature and title of certifier		29c. License i	number		29d. Date signed ( <i>Mo</i>				
	5		30. Name and address of person who completed cause of death	:h (Item 23a) (Tvpe. Pr		Piccard 1	Orive	10-10-	2010			
			G. Coleman, M.D.		Rockv	ille, MD	20850					
	Stat Registra	•	31. Date filed (Month, Day, Year) OCT 12 2010 32. Registrar's	Signature for	de la							

		Plea - For	a <b>se Type or</b> State o			artment of			_		•	
	1	State Registrar			Cei	tificate of	Death			Reg. N	lo.2010	33756
ysician	/	1. Decedent's Name (First, Middle							2. Date of D Month	D	ay Year	3. Time of Death
Medica xamine	al .	John Benjami  4a. Facility Name (if not institution				4b. City, Town,	or Location	of Death	Octobe		c. County of Deatl	1:15 a.\h.
Aannine	į	43927 Lanedon		,		Leonard		0.000			t. Mary's	
neral	- 1	5. Social Security Number	6. Sex 1 🛣 M 2 🗆 F	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days		r 24 Hrs. Min.	8. Date of Bi (Month, D 11/21/		9. Birt Cou	hplace (State or Foreign intry)
ector	- 1	214-36-4655 Usual Residence of Decedent		72	115.				111/21/	193	/_  Was	hington, DC
ed at	혅	10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
Important: If item 2/1s marked other than "natural", or items 22a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ě	Maryland St Ma	ry's	Leo	nardto	wn 10f. Zip Code				100.0	Citizen of What Co	1 ☐ Yes 2X No
ed tsu	Funeral Director	43927 Lanedon	Drive			20650					ited Sta	
in in		11. Marital Status	12. Was Dece	dent Ever in U.S		Was Decedent of f Yes, specify Cub					14. Race - Amer Black, White	ican Indian,
xamii	ρ	1 Never Married 2 X Mar 3 Widowed 4 Divorced	If Yes, Give	€	1	☐ Yes 2 🗓 N			,		Specify:	
lical E	Completed	15. Decede	nt's Education	tes.		dent's Usual Occu				16b.	Wh: Kind of Business I	ite ndustry
е Мес	티	Elementary/Seconday (0-12)	est grade completed) College (1-	4 or 5+)	life. D	kind of work done O NOT use retired		st of work	ing			
art, th	αrF	12 17. Father's Name (First, Middle, 1	Last)		Draft	sman	18 Moth	ner's Nam	e (First, Middle		vil Serv	ıce
tic ev	₽	Chester Ambros	,						ephine			
anma		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address (Stree	t and Numb	er or Rura	al Route Numb	er, City c	or Town, State, Zip	Code)
ther tr	-	Joan A. Mundie	/Wife	l not s		Lanedon	Driv			T		650
yoro		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		State C	cemetery, cren	sition (Name of natory or other pla			Date		Location - City or	
any injur	ŀ	21. Signature of uneral Service		jst.							neral Ho	Maryland ma P A
e e		Edward N. Br	insfield,	Jr. MOC	0052 22	955 Hol	Lywood	l Roa	d, Leo	nard	town, MD	20650
		23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that conly one cause on each	aused the deat ch line.	h. Do not ente	er the mode of dy	ng, such as	cardiac o	or respiratory a	rrest,		Approximate Interval Between Onset and Death
cian/ dical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (	wal.	talle	ul						Onset and Death
niner		Conventially list and ditions	Ds	alset								
12	xamine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (	or as a consequ	uence of):							
	Exan	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (	or as a consequ	uence of):				· · · · · · · · · · · · · · · · · · ·			**
completed filled in by the funeral director, page 2 should be detached for use as the burial Madian I was a street of the formulation of the formu	lca lca		d									
	Completed by Physician/Medical	 IF FEMALE:	100									
100	cian/	23b. Was decedent pregnant in the past 12 months?		come of pregna Birth 2 ☐ Feta nant at time of c	aldeath 3	Ectopic pregnar Other (specify)	псу				23d. Date of deli Month	very Day Year
10,14	is L	1	9 🗆 Unkn			2 outer (opoon)/ _						
	9	Part II. Other significant condition	ons contributing to de	eath but not res	sulting in the u	nderlying cause g	iven in Part	t I.				the cause of death?
	ered											obably 4 Unknown
c z abi	호								24a. Was auto perf	opsy ormed?	prior to death?	opsy findings available completion of cause of
		25. Was case referred to medical				26. F	Place of Dea	ath (Check	1 🗌 Yes k only one)	2 21	No 1 ∐ Yes	2 🗆 No
	2	examiner? 1  Yes 2 No	Hospital:	npatient 2 🗆	ER/Outpatier	ıt 3 □ DOA Ot	her: 4 $\square$ N	lursing Ho	me 5 XRes	idence	6 ☐ Other (Speci	fy)
	are	27. Manner of Death  1 Natural 5 □ Pendir	19	of injury h, <i>Day</i> , Yea <i>r</i> )	28b. Time of injury	woi			28d. Describe	how inju	iry occurred	
	Certificate:	2 Accident Investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place			eet, factory, office		-	28f. Location (	Street ar	nd Number or Rur	al Route Number,
		4 - Homelac determ	buildir	ng, etc. (Specify	()				City or To	wn, State	e)	
	Medical	(Check 2 Medical E		s of examination	n and/or invest	igation, in my opin	iion, death o	occurred at	the time, date	and plac	e, and due to the c	ause(s) and manner stated
	— r	only one) 3 Certifying 29b. Signature and title of certifier	Nurse Practioner:	o the best of m	y knowledge, o	death occurred at t 29c. Licens		e and plac	e, and due to t		(s) and manner as ate signed (Month	
			2	15		HO	055	75	-\	1	045-1	0
		30. Name and address of person Jennifer Schmi	who completed causedt,D.O. 40	e of death (Item	23a) (Type, F	rint)		205	Leona	rdto	own. MD 2	20650
State		31. Date filed (Month. Dav. Year)	32.86	egistrar's Signat	ture		Darre	200	Leona			
State gistrar	J.	OCT 18	2010	we k	1. ba	west						
Rev 7/2009	9				7							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MASON 21:00 M Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia Howard Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 🗆 M 2X 🗀 Davs Hours 92 12/31/1917 **Director** 213-03-9887 MD Usual Residence of Decedent or 28a-f show notified at 10a. State within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director MD Howard 1 Yes 2 No Ellicott City 10e. Street and Number item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be n 10g. Citizen of What Country? Funeral 21042 9310 Joev Drive United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 XWidowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) i Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ George F. Hilgeman Philomena Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellicott City, MD Scott Mason - son 3126 Elmmede Road permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ardent Crematory 10/14/2010 Hanover, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical e to (or as a consequence of) Examiner Sequentially list conditions Examiner If any, leading to himself cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ 23d. Date of delivery in the past 12 month
1 Yes 2 D No
9 Unknown Pregnant at time of death Unknown Dav Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? |≥ Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 No **Director:** After this certificate I in by the funeral director, page 2 1 No 1 Yes 25. Was case referred to medical B 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred Natural injury 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

10

AM: CE	END IT	EM	#4A &/	1 D	ase Type of State						<b>re All Cop</b> Id Mental		~ ~		33758
RJ	W	, 013	TYFor 10 State Registrar	/ 15/20	510		_ C	ertifica	te of L	Death		Reg.	No.		
	Physicia	ın/	1. Decedent's Nam Edwin J.	e (First, Middle	e, Last)				_		2. Date of Month		Day 13	<b>201</b> 0	3. Time of Death 09:23 M
	Medic Examin				n, give street and nu		N HOS	4b. Cit	ty, Town, or	Location of D	Death		4c. County o		1
	Funeral Director		5. Social Security N 221-16-1	lumber	6. Sex 1 ★ M 2 ☐ F	7. Age (In yrs	s. last birthda Yrs	y) If Und	er 1 Year	If Under 24	Hrs. 8, Date of	of Birth 1, Day Yea 18 I	930	9. Birth Cou	nplace (State or Foreign Delaware
	D OW		Usual Residence of	Decedent		1.00	City, Town or	Location							
	iryland a-f sh ied a	Ş	10a. State	Ceci			Elkton	Location							10d. Inside City Limits 1 ☐ Yes 2 🗶 No
	or 28;	ij	MD 10e. Street and Nu		l		- I K COII	10f. 2	Zip Code			10a.	Citizen of W	hat Cou	
	with t	Funeral Director	100 Lau	rel Dr	ive				2192	1			US		
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fun	11. Marital Status  1 XNever Mari 3 Widowed	ried 2 🗆 Mai	12. Was Dec Armed F rried 1 1 Yes		U.S. 1			ispanic Origin' an, Mexican, P Specify:	? (Specify Yes or uerto Rican, etc	No- )		- Ameri	ican Indian, , etc. White
2-0	hour "natu dical	plete	(Spr		ent's Education est grade complete	d)	16a. De	cedent's Us	sual Occup	ation during most of	working	16b	. Kind of Bu	siness li	ndustry
21215-0036	within 72 giene. er than the Me	Com	Elementary/Sec			(1-4 or 5+)	life	fer	ise retired)	adming mode of	Working.	Construction			
land	l be filed lental Hy rked oth tic event	To Be	17. Father's Name August	(First, Middle, J. Mazl	<sup>Last)</sup> ewski					18. Mother's Mary	Name (First, Mi ann Kem	ddle, Maid pczyn	en Surname) I <b>Ski</b>	•	
, Maryland	id 2 should salth and M n 27 is ma er trauma'		19a. Informant's N		hip (Type, Print) [accari (s	ister)					r Rural Route No Newark,			ate, Zip	Code)
Baltimore,	Page 1 an ent of He nt: If iten		20a. Method of Disposition   20b. Place of Disposition (Name of cemetery, crematory or other place)   20c. Location - City or Town, State   20c.												
Balti	permit. F Departm Importa any inju		22. Signatu 1 Funeral Service Licensee 22. Name and Address of Facility Becson Funeral Home 2053 Pulaski Highway, Newark, DE 19702												
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between		
C	nysician/ Medical Examiner	Ĺ	Immediate Cause disease or condition resulting in death)	on	a. Augusto	(or as a conse	17/0X.c	°C 1	~esp.	ratur	, fail	ure	-	-	Onset and Death
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	e executed cian and ourial-transit	al Examiner	Cause (Disease or that initiated event resulting in death)	iinjury ts	c. Due to	o (or as a conse	equence of):								
68760	icate by physics the b	ledic			d										
. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours and death certificate has been signed by the attending physici. To the Funeral Director Affer this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 9 ☐ Unknown	months? □ No	1 🔲 Liv	utcome of preg e Birth 2  F egnant at time o known	etal death	3		су			23d. Date Mor		ivery Day Year
s, P.O.	res that the signed by a be detact		Part II. Other signi	One.	ons contributing to	death but not	resulting in th	ne underlyin	g cause gi	ven in Part I.					the cause of death?
Records,	e law requ e has been ge 2 shoul	Completed by								_	_	Was an autopsy performed	2 p	rior to c eath?	opsy findings available completion of cause of
- H	ificate or, pa		25. Was case refer	red to medical					26 PI	lace of Death	☐ 1 ☐ Check only one	Yes 2	No 1	∐ Yes	2 No
Vita	Physician: 7 this certifice ral director, p	To Be	examiner? 1 \sum Yes 2	No	Hospital:	Inpatient 2	☐ ER/Outpa	atient 3 🗆	044	er.	ing Home 5 🗆	Residence	6 🗆 Othe	r (Speci	fv)
n of Vital	dirg Phy th. After thi fureral											njury occurre			
Division	tal or Atten rs a er deat al Director: ed in by the	Il Certificate:	3 Suicide 4 Homicide	6 Could determ	not be 28e. Plac	ce of Injury - At ding, etc. <i>(Spe</i>	home, farm,				28f. Locat	ion (Street r Town, St		r or Run	al Route Number,
_	n 24 hour n 24 hour ne Funera	Medical	(Check 2	2 Medical	g Physician: To the Examiner: On the b g Nurse Practione	asis of examina	tion and/or in	vestigation,	in my opinie	on, death occu	rred at the time,	date and pl	ace, and due	to the c	ause(s) and manner stated.
	To th within To th comp		29b. Signature and		ar .	-		2	gc. Licens	e number	0	29d.	Date signed	(Month	
	5		30. Name and add		who completed car	use of death (It	em 23a) (Typ	e, Print)	707	Bon C	+ 81	k.for.			
ange .	Sta Registr		31. Date filed (Mon		0 /2 32.	Registrar's Sig	nature	2	, -0	2000 3	+ El,	, 09			·

		-	For State Registrar	State of Ma	ryiana / Depa Cer	tificate of De			Reg. No. 2 A	10 0075		
	Dhysisis	,	1. Decedent's Name (First, Middle, La	•				2. Date of Dea	ath 20	3. Time of Death		
	Physicia Medic		BARBARA JEAN BROW					OCTOBER		010 9:30 A M		
	Examin	er	4a. Facility Name (if not institution, given RESIDENCE. 6619 H		AD	4b. City, Town, or Lo			4c. County o	of Death  E GEORGES		
	Funeral		5. Social Security Number 6. S	Sex 7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birt	th	Birthplace (State or Foreign     Country)		
	Director		241-74-3848 Usual Residence of Decedent	□ M 2 <b>T</b> F	Yrs.	IVIOITITIS Days	TIOUIS IVIIII.	JUNE 28	3,1946 N	IORIH CAROLINA		
	and show lat	ō	10a. State 10b. County		10c. City, Town or Loc	cation				10d. Inside City Limits		
	Maryla 28a-f	Director	MARYLAND PRINCE	GEORGES	CLINTON					1 <b>X</b> Yes 2 □ No		
	th the		10e. Street and Number	A.D.		10f. Zip Code 20735			10g. Citizen of WI			
	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	Funeral	6619 HORSESHOE RO	12. Was Decedent Ev	er in U.S. 13. V	Vas Decedent of Hisp	panic Origin? (Spe	ecify Yes or No-		- American Indian,		
9	ter de	þ	1 Never Married 2 X Married	Armed Forces? 1 ☐ Yes 2 🟋 N If Yes, Give	lo I	f Yes, specify Cuban,  □ Yes 2 🗶 No	Mexican, Puerto	Rican, etc.)	Black	, White, etc.		
933	ours af tural" al Exa	Completed	3 Widowed 4 Divorced	Year or Dates.					Specify:			
15-	72 hc	mple	15. Decedent's 8 (Specify only highest g	ade completed)	(Give	dent's Usual Occupati kind of work done dur O NOT use retired)		king	16b. Kind of Bus	iness Industry		
212	within giene.		12TH GRADE	College (1-4 or 5+	ACC	OUNTANT			FEDERAL	GOVERNMENT		
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		17. Father's Name (First, Middle, Last) <b>HENRY JONES, SR.</b>						Maiden Sumame) ERS JONES	3		
aryl	should to and Me		19a. Informant's Name/Relationship (	Type, Print)	19b. Mailir	ng Address (Street and	d Number or Run	al Route Numbe	r, City or Town, Sta	ate, Zip Code)		
Š	and 2 st Health a :em 27 is		LARRY C. MOORE /	HUSBAND	6619	HORSESHOE	E ROAD,	CLINTON	, MARYLAN	ND 20735		
Baltimore,	. 0 1		20a. Method of Disposition 1 □ Burial 2 【X Cremation 3 □	Removal from State		natory or other place)		Date		City or Town, State		
Itim	Pag tmer tant jury		4 ☐ Donation 5 ☐ Other (Spec							HALL, MARYLAND		
Ва	permit Depar Impor any in		LYDIA C. THORNION		$\frac{1}{3}$	HORNTON FU 439 LIVING	INERAL HOSTON RO	OME, P.A AD. IND	A. TAN HEAD.	MARYLAND 20640		
	Physician/ Medical Examiner	er	23a. Part 1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. END STACE Due to (or as a HYPERTE)	GE RENAL D consequence of): NSION		such as cardiac	or respiratory an	rest,	Approximate Interval Between Onset and Death		
	ed	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or inipury that initiated events resulting in death) Last  Due to (or as a consequence of):  HYPERLIPIDEMIA  Due to (or as a consequence of):  INFILTRATING DUCTAL CARCINOMA, LYMPH  METASTESTIS										
	cate be executed physician and the burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as a	consequence of):							
092	te be e	dical		INFILTRA METASTES	ATING DUCT	AL CARCINO	MA, LYM	PHATIC :	INVASION	)		
Box 68	ath certi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 【 No 9 ☐ Unknown	23c. If yes, outcome o	f pregnancy	Ectopic pregnancy Other (specify)			23d. Date Mon	e of delivery th Day Year		
P.O.	that the degree by the greet detached		Part II. Other significant conditions	contributing to death bu	t not resulting in the u	inderlying cause giver	n in Part I.	23e. Did to	obacco use contrib	oute to the cause of death?		
	requires the been signature of the state of	ted k						1 🗆	Yes 2 □ No 3	3 ☐ Probably 4 🛣 Unknown		
Division of Vital Records,	The law recate has be page 2 sho	Completed by						24a. Was autor perfo 1  Yes	osy pr ormed? de	ere autopsy findings available for to completion of cause of eath? □ Yes 2 □ No		
ital	Physician: The this certificate ral director, pag	Be o	25. Was case referred to medical examiner? 1 ☐ Yes 2 ※ No	Hospital:		Othor	e of Death (Chec					
of V	ding Phys th. After this funeral di	e: To	27. Manner of Death	28a. Date of injury	t 2 ER/Outpatier	28c. Injury a			dence 6 Other			
on	E is is	fical	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation		Year) injury	M 1 ☐ Ye	es 2 🗆 No					
ivisi	l or Att after d Direct	Certificate:	3		y - At home, farm, str <i>(Specify)</i>	eet, factory, office		28f. Location (S City or Tow		r or Rural Route Number,		
	To the Hospital or Atter within 24 hours after de To the Funeral Direct completed filled in by th	Medical	(Check 2 L Medical Exan	vsician: To the best of n niner; On the basis of ex- rse Practioner: To the b	amination and/or inves	tigation, in my opinion,	death occurred a	at the time, date a	and place, and due t	to the cause(s) and manner stated		
	To t with To tl		29b. Signature and title of certifier	- 8	Don		16646			13, 2010		
	233		30. Name and address of person who STEPHEN GOLDBERG		ath (Item 23a)		LD BRANC I, MARYL		E, SUITE 735	202		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month, Day, Year)

OCT 1 4 2010

32. Jegistrar's Signatury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Sept 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Thomas Moore Hyattsville If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 8. Date of Birth Social Security Number 6 Sex 7. Age (In yrs, last birthday) **Funeral** Days Hours Min Oct. 2, 1945 Country) 1 □ M 2 🛣 F NC Yrs Director 64 578-66-0266 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Prince Georges Landover 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral USA 20785 6413 Country Club Ct. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐ Yes 2 🖾 No ģ 1 Never Married 2 X Married ryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: Black If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry perunt. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic. Elementary/Seconday (0-12) College (1-4 or 5+) DC Public Schools Teachers Aide 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Fannie Cooper Arthur Lee Bell, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hyattsville, MD. 20784 4022 Meadow Trail Lane Kimberly Ford - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Lincoln Cemetery 10-9-2010 Brentwood, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Marshall—March Funeral Home of Maryland Suitland, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ terrosch disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) ass IF FEMALE: use 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? ō the 9 Unknown g 🗌 Unknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records. Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 N 2 No and 1 Yes 25. Was case referred to medical examiner?

1. Yes 2 \( \subseteq \) No 26. Place of Death (Check only one) Division of Vital Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at ë 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending Certificat 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one the 29b. Signature and title of certifie 2

Registrar

State

and address of person who completed cause of death (Item 23a) (Type, Print)

October 8- 200

Pierre Antawn Medley

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2010 33761

		1- For State Certi	ificate of	Death		R	eg. No.	,,0 0010
Physici		Decedent's Name (First, Middle,Last)				2. Date of Dea Month	th Day Year	3. Time of Death
Medical Exam	iner		<del></del>			Septembe	er 27, 2010	0034 hrs
		Facility Name (if not institution, give street and number)     Prince George's Hospital Center	4	Cheverly	or Location of Deat	in	4c, County of Prince Ge	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	t birthday)	If Under 1 Ye	ear If Under 24Hr	s. 8 Date of Bir		9. Birthplace (State or
Director				Months Da		n.	` [F	Foreign MARYLAND
		216-21-6950   1 x M 2  F   22	Yrs.			SEPT.	11 1988	— -
any			own or Location	on			-	10d. Inside City Limits
nd show	_	MD PRINCE GEORGE'S LAN	DOVER					1 Yes 2 No
Maryland 28a-f show any d at once,	)cto	10e. Street and Number		10f. Zip Code	**	1	0g. Citizen of What	t Country?
the M n or 2 tified	Director	7304 GOODLAND DRIVE		20785			USA	
with ns 23 be no	ral	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was	Decedent of H	lispanic Origin? ( \$	Specify Yes or No		American Indian, Black,
death or iter	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Ye	s, specify Cub	an, Mexican, Puert	o Rican, etc.)	White, e	etc.
after ral",	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:		Yes 2X N		=	Specify:	BLACK
hours natu			6a. Decedent' during mo	s Usual Occup st of working li	ation (Give kind of fe. DO NOT use re	work done tired)	16b. Kind of Busin	ness/Industry
-0036 I within 72 giene. ther than "	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  10TH	UNEMPL	OVED			NONE	
5-00 led with Hygiene other i	, om	17. Father's Name (First, Middle, Last)	ONEITI	OTED	18.Mother's Nam	e (First, Middle, I	Maiden Surname)	<del>.</del>
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be (	JOSEPH L. MEDLEY			TERRIE	FLEET	,	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-fah.	101	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing	Address (Stre	eet and Number or	Rural Route Nun	nber, City or Town,	State, Zip Code)
Baltimore, MD 21215-0036  bernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Oppartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho ylury or Ather transmatic event, the Medical Examiner must be notified at once.		TERRIE FLEET-MEDLEY/MOTHER				LANDOVE	R,MARYLAN	D 20785
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27		20a. Method of Disposition  20b. Pla  Two Burial 2 Cremation 3 Removal from State	ece of Dispositematory or other	ion (Name of c er place)	emetery,	Date	20c. Location - C	ity or Town, State
MO Page:	_/	4 Donation 5 Other Specify: RES	URRECT	ION CEN	METERY 10	/9/2010	CLINTON	,MARYLAND
mit.		1. Signatur of Funeral Service Licensee	22. Na	ame and Addre	ss of Facility	B. JEN	KINS FUNE	RAL HOME, INC.
<b>យ</b> ៩៤៨៣	-	1981			OVER ROAL	HYATTS	VILLE, MAR	YLAND 20785
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Defailure. List only one cause on each line.	o not enter the	e mode of dying	g, such as cardiac	or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)						Death
		b						
	ЭE	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):						
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated  Quents resulting in death) Last  Due to (or as a consequence of):						
760, icate be executed physician and the burial - transit		events resulting in death) Last  Due to (or as a consequence of):  d.						
760, cate be executed physician and the burial - trans	Medical	UNPENDED AMENDED						
Box 68760, death certificate be excheding physician of for use as the burial	Mec	IF FEMALE: 23c. If yes, outcome of pregnar	ncy				23d. Date of de	elivery
x 687 h certific ending j use as th		23b. Was decedent pregnant in the past 12 months?	- =	al death 3	Ectopic pregn	ancy	Month	Day Year
Box 68 e death certif the attending ed for use as	Physician	4 Pregnant at time of death 1 Yes 2 No 9 Unknown 9 Unknown	5 Othe	er (Specify)			-	
D. E t the d by the	P.	Part II. Other significant conditions contributing to death but not resu	ulting in the un	derlying cause	given in Part I.	23e. Did to	bacco use contribu	te to the cause of death?
ires that the signed by 1 be detache	ĝ					1 Yes	2 🗸 No 3	Probably 4 Unknown
'ds, requir	ompleted					24a. Was		re autopsy findings available
COT law i e has t	du						med? dea	
tal Rec	O	25. Was case referred to medical		26 Bloo	e of Death (Check	1 Yes	2 No 1	Yes 2 No
Vital F ysician: his certifi director,	Be	examiner?   Hospital: 4   tenetical 2   4   55	R/Outpatient				Residence 6	Other
1 of Vital Records, ling Physician: The law requir After this certificate has been s funeral director, page 2 should t	2	27. Manner of Death 28a. Date of Injury 28	8b. Time of Inj		ury at Work?	28d. Describe h	now injury occurred	
ion tendin eath.	ertification:	Fending .	350 hrs	1	Yes 2 🗸 No	Subject shot	Ì	
Division tal or Attendir s after death. al Director: A	ij	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home	e, farm, street,	, factory, office	building, etc.	28f. Location (S	Street and Number	or Rural Route Number, City
Divi	Cert	4 Homicide determined (Specify) Local Street		<u>.</u>		or Town, S 3417 Dodge P	ark Road, Lando	over, MD
		29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge,						
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/ and manner stated.	or investigatio			at the time, date		
	2	29b. Signature and title of certifier	1		se number			(Month, Day, Year)
			1 //	1,	.M.E.		September 2	7, 2010
2 4		30. Name and address of person who completed cause of death (Item 23 Russell Alexander MD. Assistant Medical Examin		Penn Street	, Baltimore, M	D 21201		
S	ate	31. Date filed (Month, Day Year) 32. Registra's Signature			.,, [1010, 101			
Regist		31. Date filed (Month, Day, Year) Size Registry's Signature 1 2 2010 Level B. Aar	Ked			OCME		

# Baltimore, Maryland 21215-0036 and Mental Hygiene. is marked other than that the death certificate be executed Box 68760 P.O. by Records, has **Division of Vital**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2<u>010</u> Physician/ Month OCTOB Year SHARON М NORRIS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) 1 🗆 M 2 🔀 F Days Hours Min 779719 0 1 1 94 1 69 Yrs **Director** 217-58-3398 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Frederick Myersville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9521 Harmony Rd. 21773 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2XXVo If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White 3 Widowed 4 K Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u>Teller</u> Bank Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Paul A. Fink Mary Louise Zecher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Robert Norris (Son) 9521 Harmony Rd., Myersville, MD 21773 20b. Place of Disposition (Name of Pare avsantty of the local pare) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Methodist Cemeterv10/11/2010 Myersville, MD 4 Departion 5 Other (Specify) <sup>22</sup>Donal Adre Bof Farthompson Funeral Home afure o POB 18, Middletown, MD 23a Part 1. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, block, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ myocardial infarction disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Coronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-1 Physician/Medical attending p for use as t IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 🕱 No Day Pregnant at time of death 1 Yes 2 9 Unknown as been signed by the 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ diabetes Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page death? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ After this 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) o the Hospital or Attending Physinia 24 hours after death.
o the Funeral Director: After the completed filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No iniury Natural Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. DØØ35267 MB 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Manuel

31. Date filed (Month, Day, Year)

A

Casiano

400

32. Regist ar's Signature

Ensun

74h S+

Frederick MD 21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				State of Mary				•	0	•
			For State Registrar	Otate of Mary		tificate of De		, 0	2010	33763
			Decedent's Name (First, Middle, La	ıst)			2	2. Date of Death		3. Time of Death
	Physicia Medi		Frances Evelvn	Ostrinsky				Month )ctober.	Day Year 03 2010	11:40 A M
-	Examir		4a. Facility Name (if not institution, giv			4b. City, Town, or Lo	ocation of Death	-85-	4c. County of Dea	th
rape of			Potomac Valley Nu			Rockvi	11e		Montgome	
	Funeral Director		5. Social Security Number 6. S	Sex 7. Age (In ) 1 □ M 2 🏋 F	78 Yrs.		f Under 24 Hrs. 8 Hours Min.	B. Date of Birth (Month, Day, Ye L 2 / 13 / 19	9. Bi	thplace (State or Foreign
			148-24-7230 Usual Residence of Decedent					12/13/19	21   1	lew Jersey
	/land f sho	ţċ	10a. State 10b. County	100	. City, Town or Lo	cation				10d. Inside City Limits
,	Mar. 28a- notifie	ire	MD Montgom	ery	Re	ockville				1 X Yes 2 □ No
	ith the 3a or the r	Funeral Director	10e. Street and Number			10f. Zip Code		109	<ol><li>Citizen of What C</li></ol>	ountry?
/	ath w	nue	1235 Potomac Vall	ey Road T12. Was Decedent Ever in	n U.S. 13. \	Vas Decedent of Hispa	850 anic Origin? (Specif	v Yes or No-	14. Race - Ame	erican Indian
စ	or ite	by F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🛣 No		f Yes, specify Cuban, I	Mexican, Puerto Ric	can, etc.)	Black, Whit	
21215-0036	ural", ural",	Completed by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates.		1 ☐ Yes 2 🛣 No	Specify:		Specify:	White
5-(	72 hou "nat edica	ple	15. Decedent's l (Specify only highest g		(Give	dent's Usual Occupation kind of work done duri		16	6b. Kind of Business	Industry
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d 2	Hygi Other ent, t	Be (	17. Father's Name (First, Middle, Last)				8. Mother's Name (F	First, Middle, Mai		ation
lan'	l be fi fental rked tic ev	₽	Benjamin Mark	cowitz		1	Sad	ie Green	field	
Maryland	should and N is ma auma		19a. Informant's Name/Relationship (		19b. Mailir	ng Address (Street and				p Code)
Σ,	nd 2 sealth m 27		Robert E. Ostri	nsky-son	18700	Muncaster	Rd. Deer	rwood, M	D 20855	
Baltimore,	pe 1 a t of H ff ite or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐		Db. Place of Dispo cemetery, cren	sition (Name of natory or other place)	Dat	te 20	c. Location - City of	Town, State
ţį	t. Pag tmen rtant:		4 Donation 5 Other (Spec	ify) J		morial Grd			Olney, MD	
Bal	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ļ ļ	21. Signature of Funeral Service Licer	tion Inc.						
			23a. Part 1. Enter the disease, or con	Approximate						
	hysician/		shock, or heart failure. List only immediate Cause (Final	one cause on each line.						Interval Between Onset and Death
	Medical		disease or condition resulting in death)	a. Pneumonia  Due to (or as a con						3 days
777	Examiner	L	Sequentially list conditions,	b Stroke						6 months
	- ±0	nin	if any, leading to immediate cause. Enter Underlying	Due to (or as a con	sequence of,:					
	and and	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c Due to (or as a con	sequence of):					
0	e be executed ysician and e burial-transit	ical		, • a	, ,					
9289	eath certificate t attending phys i for use as the l			- a						
89	certif ending use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre		Ectopic pregnancy			23d. Date of de	livery
Вох	death ne atte ed for	sicis	in the past 12 months?  1  Yes 2 No	4 Pregnant at time		Other (specify)			Month	Day Year
P.O.	es that the dec signed by the a I be detached I	Phy	9 Unknown  Part II. Other significant conditions of		t reculting in the u	nderlying cause given	in Part I	On Did to be		the cause of death?
σ.	es tha signec	l by	Part II. Other significant conditions	contributing to death but no	resulting in the d	riderlying cause given	iii aiti.			Probably 4 Unknown
rds	require been si should b	Completed by						24a. Was an		
ဝ၁	e law e has l ge 2 s	du						autopsy	prior to death?	topsy findings available completion of cause of
Ě	ician: The certificate rector, pag		25. Was case referred to medical			26 Place	e of Death (Check or	performe 1 Yes 2	No 1 □ Ye	s 2 No
Vita	<b>hysician:</b> The lav his certificate hav I director, page 2	To Be	examiner? 1  Yes 2 No	Hospital:	2 ☐ ER/Outpatier	100			e 6 Other (Spec	rifu)
Division of Vital Records,	iding Phy th. After this funeral o		27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of injury (Month, Day, Yea	28b. Time of	28c. Injury at work?	1	d. Describe how		
on	eath. eath. or: Af the fui	lica	1 🔀 Natural 5 🗆 Pending 2 🗀 Accident Investigatio 3 🗆 Suicide 6 🗀 Could not l	n	,,	M 1 ☐ Yes	s 2 🗆 No			
Visi	or Attendi after death. Director: A I in by the fu	Certificate:	4 Homicide determined		At home, farm, streecify)	eet, factory, office	28	f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
Ö	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  Within 24 hours after death.  The Funeral Director: After this certificate has been signed by the attending phyy completed filled in by the funeral director, page 2 should be detached for use as the		29a, Certifier 1 X Certifying Phy	/sician: To the best of my ki	nowledge death	occurred at the time, da	ate and place, and o	tue to the cause(	e) and manner as et	ated
	e Hos 124 h e Fun leted	Medical	(Check 2 Medical Exam	niner: On the basis of examinate Practioner: To the best of	ation and/or invest	tigation, in my opinion, o	death occurred at the	e time, date and p	place, and due to the	cause(s) and manner stated.
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	10		1 Inec	delle	Ille	D38262		00	tober 04.	2010
	4		30. Name and address of person who	,		rint)				
			Anurita Mendhira 31. Date filed (Month, Day, Year)		a natura	And the second s	Rockville	MD 208	50	
	Sta	te	OCT 1 9 201	2. Registrar's Si	griature	2				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Year Physician/  $\mathbf{P}^{\mathsf{M}}$ Edward O'Rourke Lawrence October | 2010 16 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death St. Mary's Hospital St. Mary's Leonardtown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Funeral 1 🕱 M 2 🗆 F Months Hours Min (Month, Day, Year) Director Yrs 81 213-24-3617 December 21, 1928 Pennsylvania Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No St. Mary's Maryland Leonardtown 10f. Zip Code ò 10e, Street and Number 10g. Citizen of What Country? 23a Funeral 41925 White Point Beach Road 20650 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ٥ þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White "natural" 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 4 Market Developer Public Relations Be filed 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) မ Edward O'Rourke other traumatic Sue McGraw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau O'Rourke / Wife Katherine 41925 White Point Beach Road, Leonardtown, MD 20650 Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 
Burial 2 
Cremation 3 
Removal from State October 18, 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2010 Alexandria, Virginia Signature of Funeral Service Lice 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine and -transit Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical serveri attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_ signed by the atte in the past 12 months? Month Day Year Yes 2 No 9 Unknown Records, P.O. Part II. Other significant conditions contributing to peath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ ailure 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No 2 N Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 🗌 No 2 Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the pasis of examination allower investigation, in my opinion, seal recommendation and the cause (s) and manner as stated.

3 Certifying Nurse Practioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of dertifie 0604 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nehrdao

State Registrar

31. Date filed (Month, Day, Year)

RNCP

legistrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Rita Mae O'Dea 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Doctor's Community Hospital Prince George's Lanham Social Security Numbe 1 Year If Under 24 Hrs. If Under 8. Date of Birth (Month, Day, Ye July 27, 9. Birthplace (State or Foreign Country)
Washington, DC 7. Age (In yrs. last birthday, **Funeral** Days Hours Min 1 M 2 X F 215-48-1073 **Director** 87 Usual Residence of Decedent or 28a-f show filed within 72 hours after death with the Maryland or items 23a or 28a-f sho miner must be notified at 10c. City, Town or Location 10d, Inside City Limits Director Maryland Prince George's Hyattsville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5911 34th Avenue 20782 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner ince. 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify Completed 3 X Widowed 4 ☐ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John G. Brahm Pearl R. DePriest 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark F. O'Dea / Son 2022 Forest Dale Drive, Silver Spring, MD 20903 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 10/12/2010 Alexandria, Virginia 4 Donation 5 Other (Specify) Signature of Euneral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician neuman A disease or condition resulting in death) t day Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 D Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Day Month Year Pregnant at time of death ☐ Pregnant. ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an Were autopsy findings available prior to completion of cause of page 2 s autopsy performe death? this certificate ☐ Yes 2 ☐ No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No 1 🗌 Yes ပ ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 1 □ Yes 28d. Describe how injury occurred (Month, Day, Year) 1 🗹 Natural 5 Pending 2 🗌 No Accident within 24 hours after death To the Funeral Director: / completed filled in by the Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar

only one) 29b. Signature and title of certifie Mucha

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BATTMERE

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

1)26287

Coilege PAVLE ND ZOTYO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene FoAMEND#16a per FH - State Registrar 10/12/10 AACO HEALIH DEPT. OMH Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ October 5 Marion H. Phelps Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2🛣 F Hours OC 12th, Pag Year 927 215-24-8823 82 **Director** Usual Residence of Decedent show 10b. County 10c. City, Town or Location Director r 28a-f sh notified Anne Arundel Maryland Annapolis 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? must be Funeral 1947 Drew St. 21401 USA "natural", or items edical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married ò ☐ Yes 2 💢 No Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 Divorced 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. United States life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Officer 2yrs Administration Officer Nava1 of Health and Mental Hygie If item 27 is marked other r other traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve ance. ည James Herndon Coretta Jayson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Phelps Jr(Husband) 1947 Drew St. Annapolis, Md. Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Hace of Disposition (dame of 1 X Burial 2 Cremation 3 Removal from State Memorial Gardens 10-11-10 Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) MMarne Road Secon Recilit Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) eumon Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death been signed by the should be detached if 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has performed? Yes 2 N safter death.

Director: After this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific. Be 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide
Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3. Time of Death

1600

10d. Inside City Limits

1 ☐ Yes 2 No

9. Birthplace (State or Foreign

Mary land

Black

Academy

21401

Approximate Interval Between Onset and Death

Year

Day

2 🗌 No

1 Yes

2010

Registra DHMH 17 Rev 7/2009

State

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31. Date filed (Month)

egistrar's Signatur

Box 68760 P.O. Records, Division of Vital

## Pleas

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Kenneth Lamarr Prince	State of Maryland / Department of Health and Mental Hygiene
	otate of Maryland / Department of Freditir and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene	2010	33767
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	1- For State Certificate of Death Reg. No.									00101		
Physici	an/	Decedent's Name (First, Midd										3. Time of Death
Medical Exami	ner	KENNETH L	AMARR PRINC	E				ď	<sup>Month</sup> October 9,	Day Year 2010		0650 hrs
· ·		4a. Facility Name (if not institution		_	4	b. City, Town,	or Location of	Death		4c. County o		
.*		Prince George's Hosp				Cheverly				Prince G		
Funeral		5. Social Security Number	6. Sex 7. Age	(In yrs. last birl	hday)	If Under 1 Ye		_	Date of Birt	h(MM/DD/YYYY)	9. Birth Foreign	place (State or
Director		578-08-9260	1XM 2F 2	5	Yrs.	Months Da	ays Hours	Min.	12/19/	1984		ntry) DC
		Usual Residence of Decedent										
v any		10a. State 10b. County	1	Oc. City, Town	or Locatio	n					- 1	10d. Inside City Limits
and show	5	MD Princ	ce Georges	Clint	on							1 Yes 2 No
Maryland 28a-f show any <u>1 at once.</u>	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of Wha	at Count	ry?
the h		8006 Lohr Land	e			2073	55			USA		
with ms 23 be no	uneral	11. Marital Status	12. Was Decedent E	ver in U.S.		Decedent of F						an Indian, Black,
death or ite must	Ě	1 X Never Married 2 M	Armed Forces?	X No	li fe	s, specify Cuba	an, Mexican, F	Puerto Rica	an, etc.)	White,	etc.	
after al",	by F		orced If Yes, Give Year or Dates:		1	Yes 2 X N	lo s <i>pecify:</i>			Specify:	B1	ack
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003 withi jene.	틹	12th			colle	ge Stud				None	:	
filed Hyg		17. Father's Name (First, Middle	, Last)				18.Mother's	Name (Fir	st, Middle, M	laiden Sumame)		
21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medical	Be	Roy MC William	Roy MC Williams Patricia Prince  9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City								C1-1-	7:- O- 4-\
MD 2 nd 2 shou ulth and N m 27 is n	۴											zip Code)
and 2 and 2 ealth cem 2 fraun		Patricia M. P: 20a. Method of Disposition	rince - Mothe			Lohr La ion (Name of c		CTIUI		D. 20735		own State
nore, MD 21215-0036  ages I and 2 should be filed within 72 hours after death with the Maryland nt of Fleathh and Mental Hygiene.  It: If item 27 is marked other than "natural", or items 23a or 28a-f shoother traumatic event, the Medical Examiner must be notified at once.	Ш	1 X Burial 2 Cremation	n 3 Removal from State	cremate	ory or othe	er place)		10 00	0010		•	
timen trant		4 Donation 5 Other S		Linco		emorial			-2010			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Щ	21. Signature of F. neral Service	Signature of Ineral Service Licensee Marshall-March Funeral Home of Ma 4308 Suitland Rd. Suitlnad, MD. 2									and
	-1	23a - art I. Enter the disease, or	complications that caused th	a doath Do no								6 Approximate Interval
Physician /Medical		23a. Fart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Between Onset and
Examiner	- 1	Immediate Cause (Final disease or condition resulting in death)										Death
29"	- 1		Due to (or as a conseq b.	uence or):								
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ion of Vital Records, P.O. Box 68760, trending Physician: The law requires that the death certificate be executed teath.  tor: After this certificate has been signed by the attending physician and if the funeral director, page 2 should be detached for use as the burial - transit		- UNIDENIDED	d								$\dashv$	
760, cate be ex physician ine burial	/Medical	UNPENDED	AMENDED							_		
3760, ficate be g physici s the buri	Ž į	IF FEMALE: 23b. Was decedent pregnant in th	23c. If yes, outcome  1 Live birth		Feta	Ideath 3	Ectopic p	roananau		23d. Date of d		Voor
Sox 68 death certifi e attending for use as	cia	past 12 months?	4 Pregnant at tir		=	r (Specify)		regilatioy		Month	Da	y Year
Box 68 e death certif the attending	Physician	1 Yes 2 No 9 Unk	known g Unknown		Out	, (0,000))						
that the ned by t		Part II. Other significant conditi	ions contributing to death b	ut not resulting	in the un	derlying cause	given in Part	l, j	23e. Did tob	acco use contrib	ute to th	e cause of death?
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tal Recian: The certificate		25. Was case referred to medical	· T			00 Di	6 D 11- (O)		1 ✓ Yes 2	No1 [-	<b>✓</b> Yes	2 No
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death.  The law requires that the sertificate has been signed by the funeral director, page 2 should be detached in by the funeral director, page 2 should be detached.	ŭΙ	examiner?	7.1	2 ✓ ER/Ou	toationt		e of Death (C	Nursing Ho		Residence 6	Other:	
of Vi Physi eral dir	라	1 Yes 2 No 27. Manner of Death	28a. Date of Injury		ime of Inju		ury at Work?			ow injury occurred		
n of viding Ph.	Certification:	1 Natural 5 Pend	Month Day, Year	0536	•		Yes 2 ✓ N	loub	ject shot	ow injury occurred	•	
00 2 2 2 2	g	2 Accident Inves	stigation 28e. Place of Injur	v - At home, far	rm street				Location (St	root and Number	or Burn	I Route Number, City
Divisior pital or Attenc ours after death reral Director:	퉤	deter	d not be (Specify) Com			ractory, office	bulluling, etc.	- 1	or Town, Sta			-
lospit I hour uners ly fill		4 Homicide  29a. Certifier 1 Continue Bh				d at the time of	loto and alone				_	
Divis To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	<u>8</u>	(British British	nysician: To the best of my k miner:On the basis of examin	_								
To To Con	Medical	29b. Signature and title of certifie	and manner stated.			29c. Licen				29d. Date signed		
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	-	70 Name and addition (	Wilt	th /// 20 1						30.0001 10,		
221		<ol> <li>Name and address of person Jack Titus MD. Dep</li> </ol>	who completed cause of dea	,	1 Penn	Street, Ba	ltimore MI	D 21201				
21	ate	31. Date filed (Month, Day Year)				230t, Da		0 1				
Regist	_	DCT 1 4 2010	32. Register's	Backs								

Examiner P.O. Box 68760. Division of Vital Records,

e Hospital or Attending Physician: The law requires that the death certificate be executed 124 hours after death. e Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely within 2 2

**Funeral** 

Director

28a-f show

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23a

or items

"natural"

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s 1 and 2 should be filed wi f Health and Mental Hygien item 27 is marked other th

permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tr. once.

**Physician** 

/Medical

72 hours after

Baltimore, Maryland 21215-0036

traumatic event, the Medical Examiner nest be notified at

Hyper Clusion	Bress	1 Ares	2 ☐ No 3 ☐ Probably 4 ☐ Unknown				
hype-lipid	encia			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No		
25. Was case referred to medical			26. Place of Dea	th (Check only one)			
examiner?	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient 3 DC	ome 5 Residence 6 Other (Specify)				
27. Manner at eath  1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	28b. Time of lnjury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred		
3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ie, farm, street, factory	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	ysician: To the best of my knowl niner: On the basis of examination and manner stated.				use(s) and manner as stated. te and place, and due to the cause(s)		
29b. Signature and title of certifier		290	. License number	290	d. Date signed (Month, Day, Year)		

Registrar

State

Medical

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 524 EAST ANTIETAM STREET, SUITE 260.

Hogerstown, MD 21740

136651

2010

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar		State of	Marylar		artment of rtificate of	Health and Death	Mental Hy	/gien Reg. N	2010	33769		
Physicia	ın/	1. Decedent's Nam	e (First, Middle, L	.ast) Rivera					2. Date of Do Month Octobe	Г	Day 2010	3. Time of Death		
Medic Examin		, ,	f not institution, g	ive street and numb	er)	-		or Location of Deat		4	c. County of Death	1 2140		
Funeral		Prince ( 5. Social Security N	. Age (In yrs. I	ast birthday)	Chever1			rth	Prince Geo	orge place (State or Foreign				
Director		219-75-0		1 <b>X</b> M 2 □ F	63	Yrs.	Months Days	Hours Min.	04-05-	194°	El <sup>co</sup> Salvador			
and show dat	tor	Usual Residence of 10a. State	10b. County		10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits		
e Mary r 28a-f notifie	Director	MD 10e. Street and Nur	Montgom	ery	Ro	ckvi11						1 X Yes 2 □ No		
with th	Funeral I	4613 Coac		rive			10f. Zip Code 20852			_	Citizen of What Cour Salvador	ntry?		
within 72 hours after death with the Maryland giene. et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at		11. Marital Status		12. Was Deced	ent Ever in U.	S. 13.	Was Decedent of H	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)		14. Race - Americ Black, White,			
rs after rral", or Exami	ed by	1 □ Never Marr 3 □ Widowed	ried 2 ሺ Married 4 🗌 Divorced	1 ∐ Yes 2 If Yes, Give Year or Date			1 🛣 Yes 2 🗆 No	Specify: sal	vadoran		Specify: Hisp&			
72 hou 1 <b>"natu</b> Iedical	Completed	(Spe	15. Decedent's ecify o <i>nly high</i> est	Education grade completed)		(Give		during most of wor	rking	<b>1</b> 6b.	Kind of Business Inc			
led within Hygiene. other thar ent, the M		Elementary/Sec 5th	onday (0-12)	College (1-4	or 5+)		o NOT use retired shwasher		Restaura					
1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. A grand Z is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (		t)				18. Mother's Na Mercede			n Surname)			
should and Me is marl aumati		19a. Informant's Na	ame/Relationship	(Type, Print)		19b. Maili	ng Address (Street	and Number or Ru			or Town, State, Zip C	Code)		
and 2 s Health em 27 ther tr		Me1by San 20a. Method of Disp		(Daught <b>er</b>		<del></del>	Coach1a	mp Ln. Ro	ockville Date	T	D 20852 Location - City or To	www. State		
Page 1 nent of ant: If it ary or o		1 🗓 Burial 2		Removal from S	tate	ily Ce	natory or other pla	ce) 10-	20-10	1	Salvador	wii, State		
permit. Page 1 and 2 si Department of Health a Important: If item 27 is any injury or other tra once.		21. Signature of Fu	· / J.		10	22	2. Name and Addre			Fu	neral Home			
		23a. Part 1. Enter t	the disease, or co	mp cations that ca	used the deat						1, DC 200.	Approximate Interval Between		
hysician/		shock, or heart failure. List only offe cause on each line.  Immediate Cause (Final disease or condition resulting in death)  AND TUKED ABDOMINAL ANEWRYSME  Interval Between Onset and Death Onset and Death												
Medical Examiner				Due to (or	r as a consequ	uence of):	DEMO	ting	The	7 SI	G-06	Samons!		
p	niner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	nmediate erlying	Due to (or	as a consequ	uence of):	Pag		700		2 / 1			
execute in and ial-trap	Examine	that initiated event resulting in death)	s	c. Due to o	as a consequ	uence of):	A FICE	sur c	1		7- 60	reuran		
icate be executed physician and sthe burial fransit	edical		•	La Rep	zair	- 0/	Alida	smusso	t a	02	Se	Su		
certific anding I use as	an/Me	IF FEMALE: 23b. Was decedent		23c. If yes, outco	ome of pregna		☐ Ectopic pregnan	CV			23d. Date of delive	ery		
e death the atte	Physician/M	in the past 12 i 1 ☐ Yes 2 ☐ 9 ☐ Unknown	□ No		ant at time of		Other (specify)				Month	Day Year		
that th	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to									use contribute to th	ne cause of death?		
equires seen sig hould b	eted	1   Yes 2   No 3   P												
re law r e has b age 2 sl	Completed									psy ormed?	prior to co death?	psy findings available mpletion of cause of		
cian: TI ertifical ector, pi	Be C	25. Was case referre	ed to medical	Hora-Vall				lace of Death (Che	1 ☐ Yes ck only one)	2 <b>X</b> _J1	No 1 ☐ Yes	2 <b>X</b> I NO		
Physion this caral dire	2	1 ☐ Yes 2 <b>%</b> 27. Manner of Deatl	No h	28a. Date of		28b. Time of		4 ☐ Nursing F	lome 5 Res		6 Other (Specify	)		
tending eath. or: Afte the fun	Certificate:	1 🏻 Natural 2 □ Accident 3 □ Suicide	5 ☐ Pending Investigat 6 ☐ Could no	ion	, Day, Year)	injury	M 1	ḱ? Yes 2 ☐ No						
after d Direct d in by		4 Homicide	determine	28e. Place of	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trapsic.	Medical										and manner as state ce, and due to the car	d. use(s) and manner stated.		
To the I within 2 To the I comple	M	only one) 3 29b. Signature and		Practioner: To	the best of m	y knowledge, o	29c. Licens		ace, and due to t		e(s) and manner as sta late signed (Month, I			
4			11/	/	1	5/	DI	4182		18	)-7-2			
	Ì	80. Name and adding	N	o completed cause	of death (Herr	23a) (Type, F	Print) 30	01 Hospit	al Driv	e	Cheverly	, Md. 20785		
Stat Registra		31. Date filed (Mont	h, Day, Year)	39. Reg	jistrar's Signa	bas	Ked.							

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2010 10:50 PM Dorothy Shook Buchly Reichardt 07 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Montgomery (Jenera) Hospita! Olney Social Security Number If Under 1 Year | Munder 24 Hrs. 6. Sex 8. Date of Birth Birthplace (State or Foreign Country) MD . Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 M 2 X F April 23, Year 1919 579-10-4394 91 **Director** Yrs. Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 USA 15311 Beaverbrook Court, #2A within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give ğ 1 Never Married 2 Married Baltiniore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed 3 X Widowed 4 ☐ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Secretarialpermit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Washington Gas Light Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Warren Burdette Shook Kathryn Oellig 19a. Informant's Name/Relationship (Type, Print) Elvin Warren Ringler/Nephew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1621 La Salle Avenue, McLean, VA 22102 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory 20a Method of Disposition 20c. Location - City or Town, State Oct. Date 1 Burial MI Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2010 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.

Division of Vital Records, P.O. Box 68760

	al comple	- Cra-	500 University Blv		ing, MD 20	301				
sician/	23a. Part 1. Inter the disease, or compl shock, or heart failure. List only on Immediate Cause (Final	ications that cause the death. Do not e cause on each line.		cardiac or respiratory arrest,		Approximate Interval Between Onset and Death 4 d cus				
ledical	Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):									
aminer	o'C.	Due to for as a consequence oil.				U				
je je	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):								
T table	cause. Enter Underlying Cause (Disease of linjury									
al-tra	that initiated events resulting in death) Last	Due to (or as a consequence of):								
sicia buri	L.									
cate has been signed by the attending physician and page 2 should be detached for use as the burial-tansit age 2 should be the page 2 should be detached for use as the burial-tansit bage 2 should be the physician/Medical Examiner	III COMMING									
use an/	200. Was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death								
e attrad for sicis	in the past 12 months? 1  Yes 2 No	1 Live Birth 2 Li Fetal death 3 Li Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) Month 9 Unknown								
by the	9 Unknown	37.55								
be de	Part II. Other significant conditions con		se contribute to the cause of death?							
ould lead	History of lu	2 ∐ No 3 □ Pr	obably 4 🔀 Unknov							
as be		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of							
page Con				d? death?  ¶ No 1 ☐ Yes 2 ☐ No						
his certific I director, To Be	25. Was case referred to medical examiner?	ospital:								
this of all dire	I L Yes 2 100	1 ☑ Inpatient 2 ☐ ER/Outp		rsing Home 5 Residence		5y)				
Director: After to by the funeral Certificate:	27. Manner of Death 1   Natural 5 □ Pending	28a. Date of injury (Month, Day, Year) 28b. Tim inju	ry work?		d. Describe how injury occurred					
tific	2 Accident Investigation 3 Suicide 6 Could not be	28a Flace of Injury. At home form	M 1 Yes 2							
	4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office		28f. Location (Street and Number or Rural Route Num City or Town, State)					
i fillec	29a. Certifier 1 Certifying Physic	cian: To the best of my knowledge, de	red.							
he Funeral pleted fillec	(Check 2 Medical Examination only one) 3 Certifying Nurse	e, and due to the c	ause(s) and manner sta							
To th	29b. Signature and title of certifier	. 1	29c. License number	29d. D	ate signed (Month,					
10	Dichhung M	dinh	754996	0	ctober 8	2010				
'	30. Name and address of person who co			01	2 121	vo 0				
	Bichhuong M. Din	h 18101 Pr	ince Philip Yri	ve, Olney M	908	132				
State	31. Date filed (Month, Day, Year) OCT 12 201	32/Registrar's Signature	Soll	· ·						
Registrar	UCI 1 ≈ 201	V Server B. A.	7000							
7 Rev 7/2009										
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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State	of Maryla	nd / Depa <i>Cei</i>	artment of <i>rtificate o</i>			/lental H	lygier Reg. 1	20	10	33771	
	PE	Εđ	1. Decedent's Name (First, Middle, Last)								2. Date of Death 3. Time of			3. Time of Death		
	Physici /Medic	Medical Hughes Allen Redcross									Octob	er 6	, 201	<b>D</b> ear	7:20 a м	
	Examin							4b. City, Town	, or Location	of Death		4c. County of Death				
		W.	Friends Hous					Sandy			T = = = =		Montgo			
	Funeral Director		5. Social Security Number <b>237–26–8057</b>	6. S	ex □ M 2[ <b>X</b> F	7. Age (In yr	93 Yrs.	If Under 1 Ye Months Day			8. Date of (Month,	Day, Ye.		9. Birthp Coun Virg		
	pu ,		Usual Residence of Deceder 10a. State 10b. Co			100.0	City. Town or Lo	cation	<u> </u>					1	0d. Inside City Limits	
	anyla shov	7		gome	<b>1</b> 237		Sandy Sp							Ι.	TYZYes 2 □ No	
	the M 28a-f otifie	Directo	10e. Street and Number	, доше	- Y		andy Sp	10f. Zip Code				100	Citizen of W	/hat Cour	try?	
	aor			-										nat Coun	,.	
	eath rs 23 must	era	17340 Quaker	: Lan	12. Was De	ecedent Ever in	U.S. 13.1		860 of Hispanic C	riain? (Sp	ecify Yes or		USA 14. Race	e - Americ	an Indian,	
92	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	y Funeral	1 ☐ Never Married 2 ☐		Armed 1 ☐ Yes If Yes, (	Force <del>c</del> ? s 2 ∰ No Give		Was Decedent of If Yes, specify C 1 □ Yes 2 2 1			Rican, etc.)			k, White,	etc. :an American	
Maryland 21215-0036	ural"	d by	3 ☐ Widowed 4 ▼ Divo		Year or	Dates:	160 Dogg	dentia Hausi Os	nunation			166	. Kind of Bu			
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2	filed Hygid ther ther		17. Father's Name (First, Mic	die, Last	)		Sear	stress	18. Mot	her's Nam	e (First, Mic		arment den Surnam			
au	ed ital	o Be	Ferdinand A							Clara	Ward					
<u> </u>	d 2 should Ith and Men 7 is marketraumatic	2	19a. Informant's Name/Rela		Type. Print)		19b. Mailir	ng Address (Stre				mber, Ci	ty or Town,	State, Zip	Code)	
S	0 0 0 0	١.,	Marian Hayde	n /Das	ahtar		2001	. Tofa	ıro Ho	-14 1	21574	C 1 1 17	or Cn	rina	MD 20906	
Itimore,	一 寸 が 幸	1 3	20a. Method of Disposition	T/ Dat	ISHLET	20b		sition (Name of natory or other		LIU	Date	20c	Location -	City or To	own, State	
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alti	permit. Pag Department Important: I any injury o	1	21. Signature of Funeral Sei			1		2. Name and Ad								
ñ	Perr Dep any	V 3	Inland !	JA	Ring D	1		00 Geor								
	等		23a. Part1. Enter the diseas	e, or com	plications tha	it caused the de	ath. Do not ent	er the mode of	dying, such a	as cardiac	or respirato	ry arrest,			Approximate	
100	Dhusisian	8 4	shock, or heart failure. Immediate Cause (Final	List only	one cause or	n each line.	20.	1/00	1112	v2	2	10	r-17	- r	Interval Between Onset and Death Inknown	
7	Physician /Medical		disease or condition resulting in death)	-	a. Of	to (or as a cons	editence of).	VHSU	ulti	/	HCC	41)	FUT		IKHOWH	
	Examiner	ш	DOCOLOGICAS FAILURE											U	nknown	
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due	equence of).	1 21										
	alst Bar	Examine	Cause. Enter Underlying Cause (Disease or injury that initiated events	6												
o,	exec in an	Еха	resulting in death) Last	- 8	Due	to (or as a cons	equence of):									
8760	cate be executed oblysician and the burial-transit	dical			<b>_</b> d			_								
9	tifica ig ph as th	ledi		1												
Box	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnar	nancy etal death 3[	∃Ectopic pregna	incv				23d. Date of delivery Month Day Year						
	deat e atte	icia	in the past 12 months?		Other (specify				_							
o O	at the by th tache	hys	9 Unknown													
	ires that the de signed by the a be detached f	by	Part II. Other significant co	nditions	contributing to	death but not r	esulting in the u	e underlying cause given in Part I. 23e.					Did tobacco use contribute to the cause of			
g	w require been si should b		DIABETE	<u>S /</u>	MELL	ITUS		-			1	1 Yes 25 No 3 Probably 4 Unknown				
Records,	The law requires that the death certific the has been signed by the attending page 2 should be detached for use as:	Completed	CHRONIC	RI	DNEY	015	EASE					Vas an	/as an 24b. Were autopsy findings available utopsy prior to completion of cause of			
ř		E O	HYPERTEN	SID	1						1□ Y	erformed	ormed? death? 2 <b>X</b> No 1 ☐ Yes 2 ☐ No			
Vita	iclan: The certificate h rector, page	Be (	25. Was case referred to me examiner?	-					26. Pla	ce of Dea	th (Check or	nly one)				
	physic this ce al dire	일	1 Yes 2 No		Hospital: 1	☐ Inpatient 2	☐ ER/Outpatier	nt 3□ DOA	Other: 4	Nursing H	ome 5□F	Residence	esidence 6 Other (Specify)			
Division or	ding Ph h. After th funeral		27. Manner of Dath 1 Natural 5 □ Po	endina	28a. Da (M	ite of Injury Jonth, Day Year)	28b. Time o	of 28c. Injury at 28d. Describ					be how injury occurred			
<u>S</u>	Vttendi death. ctor: A y the fu	Satio	2 ☐ Accident in	vestigation ould not b				M 1 ☐ Yes 2 ☐ No								
Ĕ	or Attendater death Director: in by the	Certification:		etermined	20e. Fid	ice of injury - At ilding, etc. <i>(Sp</i> e	home, farm, strecify)	reet, factory, offi	ce		28f. Location City or	on (Street and Number or Rural Route Number, Town, State)				
Ω	ital c Irs af Iral D				4											
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director,	edical			miner: On the	e basis of exam	knowledge, deat ination and/or ir									
	To the within 2 To the comple	Med	29b. Signature and title of ce	ertifier	and m	anner stated.		29c. Lic	ense numbe	r		29d.	Date signed	d (Month.	Dav. Year)	
	Z ₩ C O		Loss dignature and title of the	/ 1	1-	_	111-	7	357	91		1	0/6	10		
	5		18 lerly	N	ILM	wy	M)			1		1	1-1	,0		
			30. Name and address of pe	rson who	completed ca	ause of déain (II	tem 23a) (Type,			01117	-c >	72	0-		Can 1 - 4/2	
			31. Date filed (Month, Day,	14 W/	LT, MV	Programme Registrar's Signature 1	nature	UIA M	V£ ;	Suic	E de	<del>~</del> /_	5710	616	AKING MO	
0.0	Sta Regist	ate rar		2 20		dur	A. 40	Mes.	-						20402	

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Jose Luis Ramire		S I- For State Registrar	tate of Maryla		artment o <i>rtificate o</i> :		and Men	tal Hygi		20 l	0 337	7
Physiciar Medical Examin	n/	Decedent's Name (First, Middle Jose Luis )		-					Date of Deat		3. Time of Death 2318 hrs	
		4a. Facility Name (if not instituti 3 Stonegate Court	on, give street and nu	ımber)		4b. City, Town Cockeys				4c. County of I Baltimore		
Funeral Director		5. Social Security Number None	6. Sex	7. Age (In yrs. I	ast birthday) 39 Yrs		Year If Under Days Hours	_			9. Birthplace (State or Foreign Country) Hondu	ras
215-0036  be filed within 72 hours after death with mild Hygbrene. rked other than "natural", or items 23 ent, the Medical Examiner must be no	Be Completed by Funeral Director	3 Widowed 4 Di	ing Ave.  12. Was Dec Armed For 1 Yes, Give Yea or Dates:  actify only highest grac College (1	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No ord If Yes, Give Year or Dates. y only highest grade completed) College (1-4 or 5+)  Perez			10f. Zip Code 21209  13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue 1  Yes 2  No specify: Ho Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use of Labor  18. Mother's Nat Benit			White, e Specify: I 16b. Kind of Busin COnstr faiden Surname)	American Indian, Black, otc. Hispanic ess/Industry	
Baltimore, MD Department of Health and Department of Health and Important: If item 27 is injury or other traumati		Floridalma Per 20a. Method of Disposition  1	n 3 Removal fro	20b. I	6316 Place of Disposorematory or other General 22. N	Greenspation (Name of ner place)  Cemete  lame and Addre	cemetery, ery ess of Facility	Ave. B	altimo 4/10 T. R	ore, Md 2 20c Location - Ci Hondur	21209 ty or Town, State cas eral Home	
Physician /Medical Examiner	Examiner	23a. Part I. Enter the disease, or failure. East only one cause Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or hip of the Indiade events resulting in death). Last	Due to (or as a b.		f): f):	ne mode of dyir	ng, such as ca	ardiac or res <b>j</b>	piratory arre	st, shock, or heart	Approximate Int Between Onset Death	
sici pe	nysician	UNPENDED  F FEMALE: 3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Un  Part II. Other significant conditions	ne 1 Live bi 4 Pregna known 9 Unkno	ant at time of de	2 Fel	ner (Specify)		pregnancy	23e Did tot	23d. Date of del Month	ivery Day Year	?
Division of Vital Records, P.C. sopiral or Attending Physician: The law requires that hours after death. Interal Director: After this certificate has been signed by filled in by the funeral director, page 2 should be deta	Medical Certification: 10 be Completed by	25. Was case referred to medica examiner?  1  Yes 2 No  27. Manner of Death 1 Natural 5 Pence Inve 2 Accident Inve 3 Suicide 6 Could dete 4  Homicide Check only  Certifying Pl	Hospital: 1 In 28a Date of Sep 27, 28e. Place (Specify) hysician: To the best miner: On the basis of and manner start of the series of the ser	of Injury 2010 at hose to find the control of the c	ER/Outpatient 28b. Time of Ir 2317 hrs ome, farm, stree et ge, death occurr nd/or investigati	26.Pla 3 DOA  3 DOA  1 t, factory, office ed at the time, on, in my opini  29c. Licer	oce of Death (  Other 1  Apjury at Work?  Yes 2   a building, etc.  date and place on, death occurse number  C.M.E.	Check only of Nursing Hot 28d. Sub No 28f. 3 Store, and due turred at the	1 Yes  24a. Was an autops perform  Yes 2  Describe ho ject beate  Location (Stor Town, Stornegate Coot the cause time, date a	2 No 3 1 24b. Wer prior deat 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Probably 4 Unkno e autopsy findings avai to completion of cause h? Yes 2 No Other: Scene  r Rural Route Number, e, MD stated. to the cause(s)	lable of
Stat Registra	e <sup>3</sup>	11. Date filed (Month, Day, Year)		gistrar's Signatu	100	-	Jailinore	, IVID 212	-			

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death 08 Physician/ 050 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center <u>Annapolis</u> Social Security Number If Under If Unde 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** 1 M 2 F Hours 10/31/1914 London, England 213-13-5366 95 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director MD 1 Yes 2 X No Anne Arundel Crofton 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 2357 Putnam Lane 21114 USA 12 Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🙀 No Specify: Specify. 3 ₩ Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Factory Worker Rubber Factory 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Douglas Lovell Diane White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edwin Rust 2357 Putnam Lane Crofton, MD 21114 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, Atlantic Crematory 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/10/10 Glen Burnie,MD 22. Name and Address of Facility 21. Signature of Funeral Ser bal Hardesty Funeral Home P.A. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a Examiner Secure dinty list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Other (specify) been signed by the should be detached Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy within 24 hours after death.

To the Funeral Director. After this certificate I Yes 2 KNo 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital 2 1 🗌 Yes မြ 1 Parpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury work? 5 Pending Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical Ecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month. Day, Year) ess of person who completed cause of death (dem 23a) (Type, Print) 30. Name and addre

State

Registrar

31. Date filed (Month

32

2 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October Physician/ 2010 8:00 a Ridgell Agnes Lucille Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** St. Mary's 25974 Loveville Road Morganza Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Days Hours Min. (Month, Day, Year) 0/24/1921 Director Maryland 219-48-3356 88 Usual Residence of Decedent or 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c, City, Town or Location within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2XXNo Leonardtown Maryland St. Mary's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20650 40055 Busy Corner Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural" Completed 3 X Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) age 1 and 2 should be filed within 72 and of Health and Mental Hygiene.

It if item 27 is marked other than "ry or other traumatic event, the Med y or other traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u>Homemaker</u> Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျ Alfred F. Τ. Wilkinson Hammett Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 12, Morganza, Maryland 20660 Mary Jane Bowles/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If ii any injury or o 1 🛣 Burial 2 🗌 Cremation 3 🗌 Removal from State cemetery, crematory or other place) Charles Memorial Gr.: 10/19/2010 Leonardtown, MD 4 ☐ Donation 5 ☐ Other (Specify) Edward N. Brinsfield, 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650 M00052 Jr. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final cardiovascular Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last this certificate has been signed by the attending physician ral director, page 2 should be detached for use as the buria Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year Pregnant at time of death 9 Unknown 1 ☐ Yes ∠ ™ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Myocardial 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 2 No 1 🗌 Yes Division of Vital funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Demotiters examiner? Hospital: Other: 4  $\square$  Nursing Home 5  $\stackrel{\frown}{\square}$  Residence 6 $\stackrel{\longleftarrow}{X}$  Other (Specify Residence1 Yes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 Natural Accident 5 Pending 24 hours after death. e Funeral Director: Aft Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

Thomas M. Wilkinson, M.D. 23140 Moakley Street, Leonardtown, MD 20650 Registrar's Signati OCT 18 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

certifie

Medical

State

Registrar

29a. Certifier

(Check

only one) 29b, Signature and title o

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

00055682

29d. Date signed (Month,

115

10

Day, Year)

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October  $2010^{\text{Year}}$ Rochelle Rappaport Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Kline Hospice House Mt. Airy Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months 1 □ M 2 🔀 F Days Hours Min. July 25, 1 Director 1948 215-52-7045 62 Usual Residence of Decedent 3a or 28a-f show 10b. County 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location Director Maryland | Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral nan "natural", or items 23a Medical Examiner must b 1421 Taney Ave., Apt. #405 21702 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Secretary Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ David Rappaport Sophie Abrams other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher Rolle / Attorney 43 West Patrick Street, Frederick, MD 21701 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn 10/11/2010 Rockville, Marvland Signature of Funeral Service Licens 22. Name and Address of Facility Stauffer Funeral Home outn <u> 1621 Opossumtown Pike, Frederick, MD 21702</u> Ratt + Enter the disease, or complications that valued the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): the attending physician and hed for use as the burial-transit death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month 1 Yes 2 9 Unknown should be detached 9 Unknown that the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ the Hospital or Attending Physician: The law requires Records, 1 Tes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has I autopsy performe Division of Vital completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 X No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (S this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at s after death. Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

3. Time of Death

3:30 P

10d. Inside City Limits

Interval Between Onset and Death

rear

Year

Day

1 🗌 Yes

1 ¥ Yes 2 □ No

9. Birthplace (State or Foreign

New York

White

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day

ame and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature Brakeson

DHMH 17 Rev 7/2009

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33776 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ october 21 2010 **GRUSS** RENNER 8:15A M CHARLES LEO Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner CHARLES CHAS. CO. NURSING & REHAB.CNTR LA PLATA 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** JAN. 20, 1935 Days XXM 2 DF Hours MARYLAND 75 217-32-3617 **Director** Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits at Director 27 is marked other than "natural", or items 23a or 28a-f sl traumatic event, the Medical Examiner must be notified 1 XYes 2 No MD CHARLES LA PLATA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10200 LA PLATA ROAD 20646 U. S. A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 X Married 1 X Yes 2 □ No δ Baltimore, Maryland 21215-0036 1 Yes XXNo Specify. If Yes, Give Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 1 and 2 should be filed within 7? f Health and Mental Hygiene. item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) ACCOUNTANT HOTELS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 EMIL CARL RENNER MARJORIE MARIE GRUSS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SPOUSE 3820 RENNER ROAD WALDORF, MARYLAND 20662 MARY F. RENNER / Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any Injury or ott 1XXBurial 2 Cremation 3 Removal from State TRINITY MEM.GARDENS:10-27-10 4 Donation 5 Other (Specify) WALDORF, MD. 22. Name and Address of Facility RAYMOND FUNL. SERVICE, 21. Signature of Funeral Service Licenses ton 5635 WASHINGTON AVE., LA PLATA, MARYLAND M00641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ Cardiogenic arrhytmia minutes Medical Due to (or as a consequence of): Examiner Hypertension Years Sequentially list conditions, if 2 19, 1921 Examiner cause. Enter Underlying Cause (Disease or linjury Due to or as a consuluence of sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) by the attending physician stached for use as the burial Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? 1 Yes 2 No Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Disbetes Mellitus, hyperlipidemia Hospital or Attending Physician; The law requires 1 Yes 2 4 No 3 Probably 4 Unknown Completed Colon cancer, peripheral vascular 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has diseas e 1 Yes 2 No Yes 2 ANO 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 1 ☐ Yes 2 ☐ No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After (Month, Day, Year) Natural 5 Pending injury work? 1 Yes 2 No 24 hours after death. Funeral Director: A 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D006/6/4 October 2 pet, 2010

Registrar

DIC

32. Registrat's Signature

Post office Rd. waldont, mel.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ athen Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9. Birth lace (Sta Po Pand Social Security Number Funeral Y. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth ace (State or 1 🖁 M 2 🗆 F Min Hours 0342594918 92 Director Yrs items 23a or 28a-f shov 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 X Yes 2 □ No Deerfield Beach FL Broward 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 3025 Upminster #K 33442 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. White 0 Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No "natural", Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Restaurant Owner traumatic event, Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) ည Gittle Kaufman Shmuel Elimelech Shlopak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1435 Crestridge Drive Silver Spring MD 20910 Brenda Pieprz - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Eretz Hachaim 1 X Burial 2 Cremation 3X Removal from State 10/6/2010 Israel 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Tuneral Ser Danzansky-Goldberg Memorial Rockville MD 20852 M01163 22. Name and Address of Facilit Chapels Inc 1170 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Proumoni Ph sician/ disease or condition resulting in death) Medical Examiner MKnow Secuentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of that initiated events resulting in death) Last signed by the attending physician an Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Dav Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 1 Yes this certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an prior to death? autopsy perform 1 Yes 2 No ☐ Yes 2 No 25. Was case referred to medical **Division of Vital** Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner? Hospital 2 Other ျှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Nithin 24 hours after death.

To the Funeral Director: After th Manner of Death Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 101 29b. Signature and title of certifie 29c. License number 0 ne and address of ers who completed cause eath (Item 23a) (Type. State

Registrar

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Nathan

Shor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Spyros Sgourdas Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Washington Adventist Takoma Park 7. Age (In yrs. last birthday, If Unde 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F 213-58-9924 86 Months Hours Min. 5/19/24 Greece Director Usual Residence of Decedent 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director MD Montgomery Silver Spring 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8003 Takoma Avenue 20910 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔼 No Black, White, etc. 1 Never Married 2 Married ò 72 hours after "natural", or 1 ☐ Yes 2 A No Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Bus boy Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve Elias Sgourdas Yuorna Pchamis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8003 Takoma Avenue Silver Spring, Md. 20910 Dimitra K.Sgourdas/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Demoval from State Fort Lincoln 10/11/2010 Brentwood, Md. 4 Donation 5 Other (Speciff) PARTITIPAD RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Klebsiella Ineumonas disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of). that the death certificate be executed burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 4 Pregnant at time of death 9 Unknown signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cardiomyopath 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 Wo Yes 2 No 25. Was case referred to medical Be director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 █ No 2 1 Impatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physis within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0063701 Saluzasach 10/08/10

Registrar
DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036

68760

Box

P.O.

Records,

Division of Vital

SMBYASMEHT KAR

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 CM20LL AVRIVUE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #18 per FD State of Maryland / Department of Health and Mental Hygiene AACO Health Dept 10, 12-10 KAH State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** OCTOBER 6:00 A M Elizabeth Kathleen Spiegel 06,2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Arnold FutureCare Chesapeake Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (Ste Country) April 20,1940 Maryland 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 70 218-36-9172 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 X No Annapolis MID Anne Arundel Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic average. USA 21409 956 Mount Holly Drive Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married White 1∐Yes 2∭INo Specify. ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel Elementary/Secondary (0-12) College (1-4or 5+) Community College Print Shop 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ralph Charles Daffin Elizabeth Wade 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 956 Mount Holly Drive Annapolis, MD 21409 Joseph Spiegel / Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Metro Crematory, INC. Oct. 07, 2010 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Baltimore, MD 4 ☐ Donation — 6 ☐ Other (Specify) P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 21. Stanature of Frineral Se 0 23a art1. Inter the disease, or o plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List or one cause on each line. Onset and Death nmediate Cause (Final LEWY . Physician BODY DEMENTIA disease r condition resulting in death) /Medical Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, attending physician for use as the burial IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) cate has been signed by the page 2 should be detached Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1□ Yes 🖈 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCTOBER 06, 2010 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hay Suite 204 millersville, MD 21108 Negi Veterans 31. Date filed (Month, Day, Year) 2 2010 State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ERNEST W. STRICKLAND OCTOBER 10, 2010 1:15 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WILLIAM HILL MANOR EASTON TALBOT Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 255-10-8595 1 **X** M 2 □ F Months Days Hours JULY 24, 89 Director Yrs. 1921 GEORGIA Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 700 PORT STREET, BUILDING #700 21601 USA within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", WHITE 3 Widowed 4 Divorced Specify. Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working al Hygiene. HARDWARE Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filled wit Department of Health and Mental Hygier Important: If item 27 is marked other than injury or other than 1 0 SALES REPRESENTATIVE MANUFACTURER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ERNEST M. STRICKLAND LOU ELLEN WALLACE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RUDOLPH W. STRICKLAND, SON 7364 MICHAEL AVENUE, EASTON, MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State MD VETERAN'S CEMETERY 10/14/2010 HURLOCK, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 200 SOUTH HARRISON STREET, EASTON, MD MFRC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ 21206 disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed s been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 5 Other (specify) Month Day Year 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by UBESITY CORONARY ARTERY 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ANEMIA, CONGESTIVE HEART 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an as 2 autopsy s certificate ha lirector, page 2 performe FAILURE Yes 2 No 2 No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No မ 1 🗌 Yes this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 3 Suicide 4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral Completed filled

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State Registrar

Medical

29a. Certifier

only one) Signature

TIENDING MD

dress of person who completed cause of death (Item 23a) (Type, Print)

🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

LOOMING DALE AUS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10 O 2 2010 Mary Elsie Smith P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4203 Bishopmill Drive Upper Marlboro Prince George's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 M 2 X F Days Hours (Month, Day, Yea Director 217-36-6684 Maryland Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1XXYes 2 No MD Prince George's Upper Marlboro 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 4203 Bishopmill Drive USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Bace - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. Completed by 1 Never Married 2 Married Yes 2K No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify: Black 3 Wildowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8th Housekeeping PG County Government Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ Thomas H. Butler Catherine I. Belt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirlene Butler/Daughter injury or other 203 Bishopmill Dr., Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of h Important: If ite any injury or ot once. Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Veterans Cemetery 10/13/2010 4 Donation 5 Other (Specify) Cheltenham, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall-March Funeral Home man 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ (FINSON'S SEOS disease or condition Medical Examiner resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XX Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 🗌 Yes 2 😾 No Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital Other: 2XXNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) eral Director: After this filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending injury 1 Yes 2 Accident
3 Suicide 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral C Medical

State Registrar

DHMH 17 Rev 7/2009

29a. Certifier

(Check

only one 29b. Signature and title o

Dona Leskuski, 31. Date filed (Month, Day, Year

4 2010

30. Name and adress of person who completed cause of death (Item 23a) (Type, Print)

9200 Basil Court #200 Largo, MD 20774

32. Registrar's Signature

1 🗫 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

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29d. Date signed (Month, Day, Year) 10/08/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 9 Dorothy 4:38 P. M S. Thompson 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Wison Health Care Center Gaithersburg Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🛣 F Days Months Hours Min. May 28 95 Director 123-07-4724 Illinois 1915 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Gaithersburg 1 X Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 301 Russell Avenue 20877 United States item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2X☐ No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker and Mental Hygien is marked other t Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Camille Caraty Mildred Olive Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health Sandra Ey/ Daughter 10709 Huntley Pl., Silver Spring, MD 20902 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Geo<sup>eme</sup>Wash<sup>mato</sup>un of the place) Medical Center 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Columbia Mortuary Services, P.A. Signature of Funeral Service Lice /M00969 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Acute cereprovascular accident Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery Year Day 1 Yes 2 Unknown the P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic abreal tibullation. Hypertension. Records, 2 1 No 1 Yes 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? has performed? Yes 2 N rathretic Mitral \* fricus this certificate 1 Yes 2 No 25. Was case referred to medical of Vital Hospital or Attending Physician: 26. Place of Death (Check only one) Be examiner? To the Hospins.

Unwithin 24 hours after death.

To the Funeral Director: After this or completed filled in by the funeral director. 2 2 No Other: ပ္ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Division 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number H. Robert Disabluse 04115 October 10, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 20/ QUSSELLAVEIVUE

Registrar DHMH 17 Rev 7/2009

State

WIROBERT BIRSCHBACH, M

31. Date filed (Month, Day, Year)

OCT 12

GAITHERSBURG, MI) 20877

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Mpnth / 03/2/010 5:15am **Physician** Denise Thomas /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Takoma Park Washington Adventist 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Davs 578 06 6106 1 □ M 2 😾 F Washington, DC 44 09/06/66 Director Usual Residence of Decedent 10d. Inside City Limits 72 hours after death with the Maryland 10a. State 10c. City, Town or Location them 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Nedical Evantual is use to indiffed at X□Yes 2□No Washington DC Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20019 1315 Anacostia Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: Black þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) be filed within and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Private Domestic 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Inez Thomas Earl Nelson Anderson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1315 Anacostia Road SE #1 Washington, DC Pages 1 and 2 Health a Robert J. Thomas Son permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Riverdale Crematory 10/09/10 Riverdale, Md 28 Mead Aftimeral Home & Cremation 21. Signature of Funeral Service Licensee 5732 Georgia Ave NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SEPTILEMIA Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): VLCGR DEZUBITUS Examiner SACRAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-transit Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical as attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 CENAL STAGE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed HYDERLIENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy performed? page 1 ☐ Yes 2 ☐ No certificate DYMPSELET 1 □ Yes 2 1 1 1 1 1 1 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ∐Yes 2 Linc 1 ☐ mpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After thi 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death or Attending 1 Natural 5 Pending Within 24 hours after use.....

To the Funeral Director; Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide To the Hospital 1 Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D-50284

State Registrar

31. Date filed (Month, Day, Year) OCT 1 2 2010

ASMIM

1 - State Registrar

1. Decedent's Name (First, Middle, Last)

Baltimore, Maryland 21215-0036 Bus Operator Metro 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be . Pages 1 and 2 should be fil tment of Health and Mental H tant: If Item 27 is marked ott permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked, any injury or other traumatic evonce. ဂ္ John Tolbert, Sr. Beatrice Tolbert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lanham, MD. 20706 John F. Tolbert - Son 7503 Graylynn Dr. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-14-2010 | Waldorf, MD Heritage Cemetery 21. Signature of Funeral Service Licensee Marshall-March Funeral Home of Maryland 4308 Suitlnad Rd. Suitland, MD 20746 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or or mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) -DIDPULMONATE **Physician** /Medical Due to (or as a consequence of): Examiner NEUMOTEIA Se pentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed burial-transit Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 ☑ No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCTOBER 4, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Areover State Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

 $\underset{OCT}{\mathsf{Month}}$ Day **Physician** 2010 2 TOLBERT 1430 JOHN /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 □ F Yrs Sep 19, 1947 DC Director 63 579-64-2732 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location or 28a-f show d other than "natural", or Items 23a or 28a-f sho event, the Medical Evanther must be notified at 1 ☐ Yes 2 ☑ No Funeral Director Prince Georges Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7503 Graylynn Dr. 20706 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify <u>δ</u> Specify: Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th marked other than College (1-4or 5+)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) OCT Month Physician/ 9:40 P M 2010 OWENS EARL TAYLOR Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Annapolis Bayridge Nursing Home If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number Age (In vrs. last birthday, **Funeral** (Month, Day, Hours Min. Country) 1 ☑ M 2 ☐ F 1933 Yrs Oct. NC Director 578-42-4200 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f shov 10b. County 10a State filed within 72 hours after death with the Maryland Director Examiner must be notified 1 Yes 2 No Annapolis Anne Arundel MD 10f. Zip Code 10g. Citizen of What Country? ò 10e. Street and Numbe items 23a Funeral USA 21403 900 Van Buren St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Black, White, etc. Armed Forces <sup>2 □</sup> No 1953 1 Never Married 2 Married X Yes "natural", or þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Black 3 Widowed 4 Divorced Completed Year or Dates 1955 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Entreprenauer 2yrs. Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: if item 27 is marked oth any injury or other traumatic even once. ၉ Sarah Sessom David Taylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Spectator Ave Landover, MD David K. Taylor - Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State MD Veterans Cemetery 10-18-2010 Cheltenham, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses Marshall-March Funeral Home of Maryland Suitland,MD 20746 4308 Suitland Rd 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Alzheimer's Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions ner ri any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of). Exami or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic preg. 5 ☐ Other (specify) 23b. Was decedent pregnant Ectopic pregnancy Day in the past 12 months?
1 ☐ Yes 2 ☐ No Month ate has been signed by the atte page 2 should be detached for a Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Vunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performe 1 ☐ Yes 2 ☐ No After this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes ၉ 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: injury work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9055 Cheverolet Dr. Suite 103 Mitul Dave, MD 31. Date filed (Month, Day, Year) 0CT 1 4 2010 alle

Medical

29a. Certifier

only one)

29b. Signature and title of certifier

ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License numbe

29d. Date signed (Month. Day, Year)

0

Ellicott City, MD 21042

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month >oYear 2308 M Willie Alfred Woodard Medical 4a. Facility Name (if not institution, give street and humber) 4b. City, Town, or Location of Death **Examiner** 4c. County of Deat 189 28/2 -das ומכרם 9. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8 Date of Birth Funeral Days Min 1 X M 2 🗆 F 08/21/1931 Director 461-38-3655 79 Texas Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Silver Spring Montgomery 10e. Street and Number 10g. Citizen of What Country? Funeral 2812 Legendary Court 20906 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Examiner "natural", or 1 ☐ Yes 2 🗷 No If Yes, Give þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed <sup>M</sup>African-American Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Metro Bus Driver Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked Ike Woodard Hestell Nelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Aurora Mercedes Woodard/Spouse 2812 Legendary Ct., Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State injury or 1 Burial 2 X Cremation 3 Removal from State Lincoln Crematory 10/13/2010 Brentwood, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee MOIRGY 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Approximate et and Deat Immediate Cause (Final Physician/ 70 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Tage -Exami death certificate be executed Due to (or as a consequence of) resulting in death) Last the burial attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 2 No ed by the a 1 Yes 2 L 9 Unknown a 🗌 Unknown that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page performed? Yes 2 No Physician; The 2 🗌 No 1 Yes Be 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) examiner? Hospital Other: ٥ 2 🗆 No 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending Accident s after death. 1 Yes 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined To the Hospital of within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier anly one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certific MODME 2010 Sbur 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRECHER

DHMH 17 Rev 7/2009

State Registrar

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MPO 3 Day 2010 ear 1:20A M Ora Mae Washington Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring Renaissance Gardens Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) GA 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2**X** F Hours 579-28-4733 92 Director 3/12/1918 Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Examiner must be notified at Director 1 X Yes 2 No MD Montgomery Silver Spring 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a or Funeral 20904 USA 3128 Gracefield Road "natural", or items death . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: SpecifyAfrican American Completed 3 X Widowed 4 Divorced Year or Dates event, the Medical Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, the Mee College (1-4 or 5+) Elementary/Seconday (0-12) Federal Government Contract Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Hattie Battle William Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13125 Windingtrail RD, Laurel, MD 20707 Raymond Washington (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Berial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify 10/12/2010 Washington, DC Creek Cemetery 21. Signature/pf Funeral Service Lio 22. Name and Address of Facility McGuire Funeral Service, Inc. en 7400 Georgia Ave., NW Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Arteriosclerotic Cardiovascular Disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Unknown Diabetes Mellitis Type II Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of, that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): burialattending physician for use as the burial Medical Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death Yes 2 X No 9 Unknown 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? ģ Advanced Dementia Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably XX Unknown p. ge 2 should een 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

Of the Funeral Director: After this certificate has I wompleted filled in by the funeral director, p.ge 2 s autopsy performed Yes 2 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifi

Eileen Gemmell.

filed (Month, Day, Year)
OCT 12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Sig

CRNP

2010

3 Kertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3160 Gracefield RD, Silver Spring, MD 20904

29d. Date signed (Mgnth, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 33788 Certificate of Death Reg. No. , Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 3:37 KM UBJBH MICSON 93ROTOO 2010 Medical a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner CLEN BURNIE 13040AA UUA ARTHAD JADICAM 401241424W-380417JAB If Under 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) Funeral 1 M 2XX Months Days Hours Min. Mary Tand 0*67777*4*9*49 214-52-8145 61 Director Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director MD Anne Arundel Odenton 1 Yes 2X No 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 21113 USA 515 Stoney Hill Court 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. "natural", or ò 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 👿 No Specify: Black 3 🗌 Widowed 4 🙀 Divorced Completed Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cleaning Janitorial Hygiene. the other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked o traumatic eve ျှ Lucretia Matthews Ernest Watkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t. Page 1 and 2 st tment of Health a tant: If item 27 is jury or other tra 1622 East Biddle Street Baltimore, MD 21213 Charles Williams 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. cemetery, crematory or other place)
Atlantic Crematory 10/11/2010 Glen Burnie, MD 21. Signature of Funer Service License 22. Name and Address of Facility Hardesty Funeral Home P.A. Gambrills, MD 21054 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 24A 256512 Medical Due to (or as a consequence of): Examiner IWEEK CEC CELLULITIS Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate Cause (Disease or linjury death certificate be executed burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b, Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☒ No Day Month Year Pregnant at time of death the g Unknown Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown MORBID OBESITY, CHRONIC LEG LYNTHEDEMA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Physician: The Yes 2 No 1 Yes 2 X No **Division of Vital** 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 KInpatient 2 ER/Outpatient 3 DOA 1 Yes 잍 this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending work?
1 Yes 2 No iniury 1 🔀 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State

Registrar

DHMH 17 Rev 7/2009

egistrar's Signature

D0065714

301 HOSPITAL DRIVE, GLEH BURHIE, MD 20161

OCTOBER9, 2010

OH, Esolginas Des Composer, HD

GUILLERMO JOSE CIANGRECO

31. Date filed (Month Day

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mary Margaret Wood 6:15 A M 2010 October Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's 38707 Colinwood Road Abell 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year \_\_\_ If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) June 13, 1944 1 □ M 2 🕱 F Months Days Hours Country) Maryland Director 66 Yrs 214-42-6057 Usual Residence of Decedent 28a-f show with the Maryland 10a. State 10b. County 10c. City, Town or Location be notified at 10d. Inside City Limits Director St. Mary's Abel1 1 Yes 2 X No Maryland 10f. Zip Code ō 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 20606 USA the Medical Examiner must 38707 Colinwood Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. "natural", or ģ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. The Man Elementary/Seconday (0-12) College (1-4 or 5+) Receptionist Doctors Office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Robert Archie Owens Mary Frances Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Joseph Wood/ Husband 38707 Colinwood Road Abell, Maryland 20606 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sacred Heart
Catholic Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State October 20, 4 ☐ Donation 5 ☐ Other (Specify) Bushwood, Maryland 2010 21. Signature of Funeral Service Licens e 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. Tichael eparolines P.O. Box 270 Leonardtown, Maryland 20650 23a. Part (. Enter the disease, or compressions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ ComplicaTIONS disease or condition resulting in death) CrANIO Plasty DAYS Medical Due to (or as a consequence of): Examiner 506 ANACHANOID nemmorrhage month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit ANKURISM CEREBARL Cause (Disease or iinjury that initiated events resulting in death) Last attending physician Physician/Medical that the death certificate be Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? detached for Month Pregnant at time of death the 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available has autopsy prior to completion of cause of death? perform 1 Yes 1 Yes 2 1 completed filled in by the funeral director, 25. Was case referred to redical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 \( \text{Nursing Home} \) 5 \( \text{Hesidence} \) 6 \( \text{Other} \) Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at work?
1 Yes 2 No 28a. Date of injury (Month, Day, Year) After t Certificate: 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural 5 Pending iniurv Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29c. License number 29d. Date signed (Month, Day, Year) loved M. Ficheles 734188

State

31. Date filed (Month Day 18 2010 Registrar

David M. Federle

24035 Three Notch Road Hollywood, Maryland Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month OCTOBER Physician/ WILLIAM HARRY 2010 WARD Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Jan. 30,1933 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Months Hours Min. Country) 214-28-8881 **Director** Washington D. Usual Residence of Decedent 28a-f show ä 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2X No Frederick Maryland Frederick 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 5203 Ivywood Drive South 21703 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married "natural", or þ X Yes Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: Completed 3 Widowed 4 Divorced Year or Dates. 1952-55 White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Electronic Technician Electrical Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ပ William H. Ward Gladys Nichols 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i B. Dianne Ward/ Wife Ivywood Drive South, Frederick, Maryland 21702 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 🛮 Burial 2 🗌 Cremation 3 🗀 Removal from State 4 ☐ Donation, 5 ☐ Other (Specify) Mt. Olivet Cemetery 10/12/2010 Frederick, Maryland 21. Signature of uneral Service 32. Name and Address of Facility Stauffer Funeral Homes P. A. 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Septic Shock
Due to or as a consequence of): Priysiciani disease or condition resulting in death) Medical **Examiner** Preumonia Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impory Due to (or as a consequence of) attending physician and for use as the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown 2 🗌 No Division of Vital Records, P.O. ed by t signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig page 2 should b metastatic lung cancer 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Physician: The Yes 2 

No 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No မှ 1 K Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 5 Pending 1 🗷 Natural work 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Aurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

Registrar

only one) 29b. Signature

and title of certifie

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OCT

31. Date filed (Month, Day, Year)

30. Name and address of per on who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

29c. License number

Frederick mo

D0065378

29d. Date signed (Month, Day, Year)

101

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Pay, Physician/ October 2090 5:00 A<sub>M</sub> CHARLES EDWARD WELSH, JR. Medical 4a. Facility Name (if not institution, give street and number) 4h City Town, or Location of Death c. County of Death Frederick **Examiner** 13263 Catoctin Furnace Road Thurmont 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 ∏ M 2 □ F June 21, Year) 932 Months Days Hours Min Pennsylvania 78 Yrs. Director 217-28-5174 Usual Residence of Decedent 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Frederick Thurmont 1 Yes 2 No Maryland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21788 13263 Catoctin Furnace Road 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Machines 12 Machinist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Dorothy Wastler Charles Edward Welsh, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberta L. Welsh / Daughter-in-law 13263 Catoctin Furnace Road, Thurmont, MD 21788 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town. State Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Blue Ridge Cemetery 10/12/2010 Thurmont, Maryland 22 Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES 615 EAST MAIN STREET, THURMONT, MD 2 21. Signature of Fungral Service Licen 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death tailuxe Immediate Cause (Final ongestive Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): ewho (overnam haut diese Examiner athe Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician OPD Physician/Medical Division of Vital Records, P.O. Box 68760 for use as the NA IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Other (specify) Pregnant at time of death signed by the at d be detached for 4 ☐ Pregnant 9 ☐ Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy After this certificate Yes 2 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 2 No Hospital: ပ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of \_\_ 28c. Injury at Certificate: 28d. Describe how injury occurred work? injury Natural 5 Pending 24 hours after death. Funeral Director: A Investigation Accident completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) within 2 To the 1 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D00570+ 20 0 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nirmal K. Shah, MD FACC, 180 Thomas Johnson Drive Suite 202, Frederick, MD 21702 31. Date filed (Month, Day Year) 32. Regist ar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2010 4:00 PΜ -arry Oct /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner Talbot Genesis HealthCare - The Pines Easton Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days 1.2 M 2□ F 03-20-1924 Delaware Director 222-10-8203 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 shov any Injury or other traumatic event, the Medical Eventher must be notified at 1 Nes 2 No Director castor Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 160 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Dres 2 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Larry West Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) perator Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hnnie ဂ Wrence. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Locust St. md. 21601 Egston So. eona Demby 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Nation 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hurlock, Md Md. Veterans Cem. 10-13-10 22. Name and Address of Facility Bennie Smith Fuherd Home 21/Signature of Frineral Service Licensee il Easton 426 Dover Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician cancer ung disease or condition resulting in death) /Medical Due to (or as a corresquence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine signed by the attending physician and d be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 3 Probably 4 Unknown 2 🗌 No cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Vieles certificate mollans 1 ☐Yes 2 ☐No 2 funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 24 hours after death.

Funeral Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) within 2. and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number

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State Registrar 31. Date filed (Month, Day, Year)

OCT 12 2010

2. Pegistrar's Signature

Deve B. Sauls

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d cause of death (Item 23a) (Type, Print)

MD

**ORIGINAL** 

Please Type or Print in Black Indelible leke Firstyre At Agories Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 2010 Ora Lee Wiley 1:05p M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Memorial Hospital Havre de Grace Harford 8. Date of Birth (Month, Day, Year)
Nov 10, 19 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 ☐ M 2 🗓 F 66 Yrs. NC Director 218-40-6635 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show the Medical Exeminer must be notified at 1 ☐ Yes 2 No Completed by Funeral Director Ceci1 Colora 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2042 Colora Rd. 21917 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 🗆 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Caretaker Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be Heelth and Mental Neil Aldridge 20 Lilly Lee Starnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Heelth Vickie McConnell/ daughter 2042 Colora Rd. Colora, MD 21917 other Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages i = 10/18/2010 ō 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Depertment of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Gardens Aberdeen, MD 21. Signature Annual Service Licensee 22. Name and Address of Facility
R.T. Foard Funeral Home, P.A.
111 S. Queen ST. Rising Sun, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death MYOCARDIAL Immediate Cause (Final INFARCTION Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (un as a consequence of) Examine use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 1 Yes Hospitel or Attanding Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Medical Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 1 Anatural 5 Pending efter death. 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 🗆 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4 T Homicide within 24 hours e To the Funeral C 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 0069118 29b. Signature and title of certifier 3 30. Name an address of person who completed cause of death (Item 23a) (Type, Print) UNION AVE HAVREDEGARCE MD 21078 UTHAWALA, MD 501

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) OCT 1 5 2010

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Oct. 10, Elanor Weaver Anna Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Clinton Prince George's 6906 East Clinton Street 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7, Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XXF Days Min. Months Hours July 29. New Jersey 91 577-14-3170 Yrs **Director** Usual Residence of Decedent 28a-f show if item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location Director Prince George's Clinton Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20735 6906 East Clinton Street USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Completed 3 XXWidowed 4 □ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Company Operator 1 contracts Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lucy Nicolson Eurie Greet 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Cynthea Burns - Niece Belair, MD 21014 318 Fulford Ave 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory October 20, 2010 Clinton, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc. M01533 6633 Old Alexandria Ferry Road, Clinton, MD 10\_ 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cruses ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use one and line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine to (or as a consequence physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Pregnant at time of death signed by the a Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 1 ☐ Yes 2 ☑ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 5 Pending Division 2  $\square$  No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Output

Dertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

Ам

2:17

10d, Inside City Limits

20735

Day

29d. Date signed (Month, Day, Year)

Approximate Interval Between

nset and Death

Year

1 Yes 2 No

within 24 hours a To the Funeral D

State Registrar

person who completed cause

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are and title of cer

only one 29b. 3km

of death (Item 23a Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amend#20b&20cperfuneralhomel@drifficare 0f plant b 1. Decedent's Name (First, Middle, Last) Physician/ October 10 2010 Year Lurline I. Wright 11:00A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 16803 Old Field Lane <u>Huqhesville</u> Charles **Funeral** . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Months 1924 Arizonia Hours November 28 567-26-8035 Director 85 Usual Residence of Decedent 28a-f shov 10a State 10b. County 10c. City, Town or Location items 23a or 28a-f sho er must be notified at **Funeral Director** 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Charles Hughesville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 16803 Old Field Lane 20637 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Jral", or iter 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2XX No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", If Yes, Give Completed 3 X Widowed 4 ☐ Divorced Specify: White Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than an Elementary/Seconday (0-12) College (1-4 or 5+) 12th <u>Accountant</u> Yavap<u>ai County</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Roy Otto Vincent <u>ottie McGovern</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Carol Wright/ Daughter</u> 6803 Old Field Lane, Hughesville, MD. 20637 20a. Method of Disposition 20b. Riace of Disposition (Name of Certification) of Circles y 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Mem. Cemetery Oct. 15, 2010 Kearny, AZ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd. Waldorf, MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death .Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami ng physician and as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ate has been signed by the atte page 2 should be detached for 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, Completed 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 🗌 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 - Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Deatl 28b. Time of 28c. Injury at work? Natural 28d. Describe how injury occurred 5 Pending Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) s of person who completed cause of death (Item 23a) (Type, Print) 2B15 in Certy 120% 2+) 100 31. Date filed (Month, Day, Year) State OCT 1 9 2010 Registrar

10-07736 Aaron Williams

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible., State of Maryland / Department of Health and Mental Hygiene

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		- For State	,	Certifi	icate of	Death		F	Reg. No.				
Physician	/	1. Decedent's Name (First, Middle,Last) Aaron Melvin Williams							ath Day	Year	3. Time of Death 1105 hrs		
Medical Examine			IAMS _		October 8, 2010								
	4	ta. Facility Name (if not institution, give Southern Maryland Hospita		Death		rince Ge							
Funeral		5. Social Security Number 6. Sec	7. Age	(In yrs. last I	oirthday)	If Under 1 Yea		24Hrs. 8. Date of B	irth(MM/l	DD/YYYY) !	9. Birthplace (State or oreign		
Director	!	578-60 <b>-</b> 4166	M 2 F	65	Yrs.	Months Day	s Hours	05/10	)/194	45	Country) DC		
8	_	Jsual Residence of Decedent		Oc. City, To	up or Locatio	nn			_		10d. Inside City Limits		
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Aaryland 28a-f show Latonse.	<u> </u>	MD Prince (	eorges	Temp	1e Hi	LLS 10f. Zip Code			10g. Citiz	zen of What	Country?		
the Maryland n or 28a-f sh						2074	. 8			USA			
with the 1s 23a pe noti		3420 Rickey Ave.	12. Was Decedent E	ver in U.S.		Decedent of His	spanic Origin	? (Specify Yes or N			American Indian, Black,		
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.		1 Never Married 2 Married		Νο				Puerto Rican, etc.)					
s after ral",			If Yes, Giva Year or Dates:	latad\ 16		Yes 2 X No		nd of work done			Black ness/Industry		
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36 Thin 72 than than edical	1	10th			Banque	et Chef			N	avyYa	rd		
5-00 ed wii lygien other	탉	ᆰ	Completed	17. Father's Name (First, Middle, Last)			•			Name (First, Middle,			
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and 2 sho ealth and em 27 is traumati	H	Sonja Williams -	Wife		e of Disposit	23rd Partion (Name of ce		Temple Date			ity or Town, State		
Baltimore, MD 21215-003 pernit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other injury or other traumatic event, the Med	١	1 X Burial 2 Cremation 3	Removal from Stat	o l	natory or oth	erplace) 1 Cemete	erv	10-19-201	ols	uitla	nd, MD		
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Box 687 e death certific the attending 1 ed for use as the	Sician	past 12 months?	4 Pregnant at t	ime of death	- =	ner (Specify)							
<b>Ⅲ</b> %	≥L	1 Yes 2 No 9 Unknown	3 Olikilowii				in the Board	L 220 Did	tobosos	uso contribu	ute to the cause of death?		
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Division of Vital Rec To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	Medical		an: To the best of my On the basis of exam	knowledge, nination and/	death occur or investigati	red at the time, do on, in my opinion	n, death occi	e, and due to the cal urred at the time, dat	use(s) an e and pla	ace, and due	e to the cause(s)		
To the within To the comple	Mec	29b. Signature and title of certifier	and manner stated.			29c. Licens	se number		29d.	Date signed	(Month, Day, Year)		
		1) _ m _	_ ~			O.C.	.M.E.		Oct	ober 9, 2	2010		
12 5		30. Name and address of person who Donna M. Vincenti, MD	completed cause of de Assistant Medic			Penn Street	t, Baltimo	re, MD 21201					
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar		west.								
Registr		OCT 1 4 2010	known p	. A a	V.								

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 2 Tobe Physician/ 2010 Jenea Latrell White Medical a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Chevert Social Security Number If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthday) 33 vrs 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Month: Days Hours Min (Month, Day, Country) Washington 217-17-5637 1976 Director DC Nov. Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MDPrince George's Bladensburg 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5511 Decatur Street 20710 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give Year or Dates **Black** Specify Completed 3 Divorced 4 Divorced 15: Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Many injury or other traumatic event, the Many once. Elementary/Seconday (0-12) College (1-4 or 5+) years Administrative Officer NTHBe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James W. White Jessie Perry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Jessie White/Mother</u> Decatur Street Bladensburg, MD 20710 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Perry-Lightfoot or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/16/2010 Chaponoke, NC ature of Funeral Service Licensee 22. Name and Address of Facility Marshall-March Funeral Home 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Muyen Physician/ Medical resulting in death) (or as a consequence of): Examiner Sequentially list conditions, if any, leading to manieciate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death signed by the and be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Ardiomyo 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available 24a Was an prior to completion death? certificate has performed 2 🖸 No Yes 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1- Natural 5  $\square$  Pending 1 Tes 2 No Accident 24 hours after death Funeral Director: completed filled in by the investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

() 15 State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No 2. Date of Death L Decedent's Name (First, Middle, Last) Month 8:52 P M Physician/ 2010 October Elaine Wheeler Doris Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Montgomery Bethesda Suburban Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 7. Age (In yrs. last birthday) Social Security Number **Funeral** (Month, Day, 7/31/1 Months Hours 1 □ M 2 🖾 F Pennsylvania 579-26-5389 Director 86 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10b. County 10c. City, Town or Location 10a. State Examiner must be notified at Director Hyattsville Prince George's 1 X Yes 2 No MD 10f. Zip Code 10g. Citizen of What Country? ō 10e. Street and Number 23a USA Unit 204 20781 3831 Hamilton St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 5 1 Never Married 2 Married ş Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2X No Specify Black If Yes, Give Specify. "natural", 3 X Widowed 4 □ Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Health Care Registered Nurse traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be file 7 and Mental F 7 is marked ot ၉ Lillie Mae Broadus James A. Gaskin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health and Important: If item 27 is n. any injury or other traums 19a. Informant's Name/Relationship (Type, Print) 1935 Upshur St., NW Washington, DC James A. Wheeler, III / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Ft. Lincoln Cemetery 10/16/2010 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funer Sey e Licensee 20722 3401 Bladensburg Rd Brentwood, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Congestive Heart Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to for as a consequence of burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 X No Month Day Year Pregnant at time of death 5 Other (specify) ed by the a detached f signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 🗌 No 3 🗌 Probably 4 🔀 Unknown Chronic Obstructive Pulmonary Disease, Anemia Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 autopsy performed' 1 ☐ Yes 2 ☐ No Yes 2X No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗓 No ၉ 1 XInpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔀 Natural  $5 \square$  Pending 1 ☐ Yes 2 ☐ No death. Accident Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide after deat 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 ... only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and Me of certifier 10/09/2010 0008405 12,000 Nuto

State Registrar

DHMH 17 Rev 7/2009

8600 Georgetown Rd.

20814

Bethesda, MD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's S

J. David Guezara-Nieto, MD

31. Date filed (Month, Day, Year)

OCT 1 4 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Virginia Fowler Willix 5:50 Рм 2010 October 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Montgomery Village Health Care Montgomery Village If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, November Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Hours Washington, DC 579-34-1666 81 1928 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits the Maryland Director Gaithersburg 1 X Yes 2 No Maryland Montgomery 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral 23a Page 1 and 2 should be filed within 72 hours after death with 20877 22 Brighton Drive USA items ; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces ò 1 Never Married 2 Married ģ Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes. Give Specify: White "natural", 3 X Widowed 4 ☐ Divorced Completed Year or Dates other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Department of Defense 12 Accounting Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Harry Fowler Evelyn Louise Wilson and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 Brighton Drive, Gaithersburg, MD 20877 item 27 Cindy L. Tominovich / Niece 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ₽ <u>∓</u> 9 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Department of Important: If any injury or 10/11/2010 Brentwood, Maryland 4 Donation 5 Other (Specify) Fort Lincoln Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, PA Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) Cerebrovascular Accident Medical Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami attending physician and for use as the burial-transit Hypertension that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 X No Day Month Year Pregnant at time of death signed by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by tal or Attending Physician: The law requires units after death.
ral Director: After this certificate has been signing in the control of the c 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes 2 🕱 No Yes 2 X No 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify, 1 Yes 2 🔀 No ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 24 hours Medical 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hou To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Dr. Vinu Ganti, 19529 Doctor's Drive, Germantown, Maryland 31. Date filed (Month, Day, Yea OCT 1 2 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

only one

3 29b. Signature and title of certifie

29c. License number

D41162

29d, Date signed (Month, Day, Year)

October 7, 2010

20874

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month WARD ANNA BELLE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Plata Medical Center Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 □ M 2 X Months Days Min DEC 30 <sup>rear)</sup> 19<u>30</u> VIRGINIA 229-36-6946 79 Director Yrs Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified 1 🗆 Yes 2 ื No PORT TOBACCO CHARLES MD 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be 23a Funeral U. S. 20677 6915 GRAYMAR LANE items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 9 þ 1 Never Married 2 Married 1 ☐ Yes 2 🖾 🛪 o Specify: "natural" 3X Widowed 4 Divorced Specify: WHITE Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Baltimore, Maryland 21215-(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) AT HOME HOMEMAKER 12 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည EVE MARY BLYTHE GEORGE WYANT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trace 6915 GRAYMAR LANE PORT TOBACCO, MD 20677 PATRICIA THOMPSON/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State OCTOBER 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 22,2010 ALEXANDRIA, VA 4 ☐ Donation 5 ☐ Other (Specify) METRO.CREMATORY RAYMOND FUNL. SERVICE, P.A. Signatore of Funeral Service Licensee 22. Name and Address of Facility Bat WASHINGTON AVE., LA PLATA, MD20646 M00641 5635 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final KO C Physician/ disease or condition Medical resulting in death) a consequence of): Examiner OAF Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin -transit Cause (Disease or linjury that initiated events resulting in death) Last and the burial attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a Part II. Other significant conditions confiduating to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 3 Probably 4 Unknown 1 Yes 2 0 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has performe certificate 1 ☐ Yes 2 ☐ No Division of Vital funeral director, 25. Was case referred to 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manne f Death 28b. Time of Certificate: After \* 28c. Injury at 28d. Describe how injury occurred Matural 5 🗆 Pending Accident Suicide within 24 hours after death To the Funeral Director: A 1 Yes 2 No Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatu 29c. Liceni 29d. Date signed (Month C 30. Name and address of person who completed cause of death (item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

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ON

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3380 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Chober 00 JACQUELINE ANN BALI Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore otal N/A 8. Date of Birth (Month, Day, Year) MAY 25 1 Under 1 Year If Under 24 Hrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕮 Hours Min **Director** 62 Yrs. 219-50-0325 NORTH CAROLINA 1948 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No BALTIMORE MARYLAND N/A10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 427 ROBERT STREET 21217 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. by 1 Never Married 2 Married 1 Yes 2XXNo Specify. If Yes, Give Specify: BLACK 3 Nidowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) RADDISON @ CROSS KEYS 12th grade HOUSEKEEPING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOHN FOGG MARY HOLLAND 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Farrell/Sister 1045 Bayner Rd., Baltimore, Md., 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 11-05-10 OWINGS MILLS, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ almonary disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be execute that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ disorder Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 XN 2 🗌 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Ves 2 2 27. Manner of Death ၉ 2 🗌 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No 5 Pending within 24 hours after death.

To the Funeral Director: A Accident Investigation 3 🔲 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of

State Registrar E//en (en 31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland		irtment of I tificate of I			Reg. No.	33802		
	Physicia Medic		Decedent's Name (First, Middle, Last Remell	Brown				2. Date of Dea		3. Time of Death 9:14 cum		
	Examin		4a. Facility Name (if not institution, give Doctor's Communit			4b. City, Town, o Lanham	r Location of Death	4c. County of Dea				
	Funeral Director				st birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt 02-24-1	v_Year) Co	rthplace (State or Foreign ountry) ch Carolina		
	tryland a-f show iled at	Director	Usual Residence of Decedent  10a. State 10b. County  MD Pe		Town or Loc Upp	ation er Marlb	oro			10d. Inside City Limits		
	vith the Ma 23a or 28a st be notif	ıral Dire	10e. Street and Number 131 Weymouth St.			10f, Zip Code 20	774		10g. Citizen of What C	zen of What Country?		
9036	permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 [X Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ric  1  Yes 2 No Specify:  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired)  Housewife			ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Bla	te, etc.		
Maryland 21215-0036	rithin 72 hou iene. r than "natu the Medica	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Seconday (0-12)	ducation de completed) College (1-4 or 5+)				sing	16b. Kind of Business  Private	s Industry		
rland 2	d be filed w Aental Hygi trked other tic event, t	To Be	17. Father's Name (First, Middle, Last) James Palmer		··-		18. Mother's Nam Rosa	ne (First, Middle, Wright	Maiden Surname)			
	id 2 should salth and N n <b>27 is m</b> a er trauma		19a. Informant's Name/Relationship (Ty Mary Mundey-Daugh	pe, Print) ter		r, City or Town, State, Z Pro, MD 207						
Baltimore,	Page 1 an ment of He ant: If iten ury or oth		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif)	20c. Location - City o Washington								
Balt	permit, Departr Importr any inji		21. Signature of Funeral Service Lice	rel anoil			ss of Facilit <b>R</b> ona lleport Lr		or II FH Plains, M	20695		
	hysician/		23s, Part 1. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final disease or condition	A A 32 A			ng, such as cardiac			Approximate Interval Between Onset and Death		
7	Medical Examiner		resulting in death)	a. Due to (or as a conseque	ence off.		ों गां					
1 20	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to for as a consequence SEPS			ソペラ		NE			
760 AN	cate be executed physician and s the burial-transit	edical Ex	resulting in death) Last	Due to (or as a conseque	ence of):							
Box 6876	To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death.  Within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnan 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 L	Ectopic pregnand Other (specify)	су		23d. Date of de Month	elivery Day Year		
, P.O.	es that th signed by be detac	þ	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the ur	nderlying cause gi	ven in Part I.		obacco use contribute t	o the cause of death?		
cords	law requir nas been 8 e 2 should	Completed						24a. Was a	an 24b. Were at	utopsy findings available completion of cause of		
al Re	iian: The artificate I ctor, page	Be Cor	25. Was case referred to medical examiner?			26. P	lace of Death (Chec	1 🗆 Yes		es 2 No		
of Vit	ng Physic ter this ce neral direc	욘	1 Yes 2 No 27. Manner of Death		pital: 1			g Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred				
Division of Vital Records,	r Attendir ter death. rector: Af by the fu	Certificate;	1			Yes 2 No		Street and Number or Ru	ural Route Number,			
ρί	Hospital o Hours aft uneral Di ted filled in	Medical C	29a. Certifier 1 Certifying Phys	sician: To the best of my knowle	edge, death o	ccured at the time	e, date and place, ar	nd due to the cau	use(s) and manner as st	ated.		
	To the I within 2 To the I co⊞ple	Me	only one) 3 Certifying Nurs 29b. Signature and title of certifier	e Practioner: To the best of my	knowledge, d	eath occurred at the 29c. Licens	e time, date and place	ce, and due to the	e cause(s) and manner at 29d. Date signed (Mont	s stated.		
	5		30. Name and address of person who c	ompleted cause of death (Item	23a) (Type, Pi	rint)	DD 5818	32	10-26	- 20/0		
	J		Cecil D. Ge 31. Date filed (Month, Day, Year)	ompleted cause of death (Item:  Or 9 © 7500  32. Registrar's Signatu	ITAN	over Pa	rkway, su	ite 10	1A, Green	belt, MU 20770		
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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5126 P M SEPTEMBER STOCKTON BUZBY 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death HARFORD GARDENS CARE & REHABILITATION BALTIMORE 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Birthp... Country) NY **Funeral** 1 🔯 M 2 🗆 F Months Hours h, Day, Year) 4. 1945 **Director** 213-48-0999 JUNE 65 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No FREELAND BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2232 BULLS SAW MILL 21053 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: If Yes Give 3 Divorced 4 X Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) STEEL MILL 12TH STEEL WORKE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 HARRY BUZBY unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STARR HERRON/FRIEND 2232 BULLS SAW MILL RD., FREELAND, MD 21053 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/05/2010 | HANOVER, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityWESLEY CHAVIS, JR, FNRL. HM. 2007-09 EASTERN AVE., BALTIMORE, MD 21231 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. 23a. Part 1. Enter the disease shock, or heart failure Onset and Death Immediate Cause (Final Physician/ une disease or condition Medical resulting in death) Due to (or as a con equence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injuly that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and s the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ed by the a detached fi 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 🗌 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: မ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I After this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural vithin 24 hours are: ....
To the Funeral Director: Aftr 5 Pending 1 Yes 2 🗌 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 16W m.D 700 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Farkanale 9813 waltham wood 123 Ste 204 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 33804 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 10-24-2010 Physician/ Frederick B. Baldwin Jr. 0054 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford Birthplace (State or Foreign Country)
 MD Social Security Number If Under 1 Year 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min 09-27-1931 79 Director 215-30-8550 Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits Director 28a-f MD Harford Bel Air 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? Funeral 23a 1024 Seamount Rd 21015 USA items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. and Mental Hygiene. 1 X Yes 2 If Yes, Give Year or Dates ₫ 1 Never Married 2 Married 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) US Government Estimator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frederick B. Baldwin Sr. Hazel Whiteford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sk Department of Health a Important: If item 27 is 1024 Seamount Rd Bel Air, MD 21015 Joan Baldwin (Wife) any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Bayview Crematory 10-26-2010 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) jastrointestinal Unknown Medical Due to (or as a consequence of): Examine hours neumoberitoneum Sequentially list conditions Completed by Physician/Medical Examine if any, leading to immediate cause. Enter Underlying Cause (Cause Underlying Cause (Cause Underlying Cause Underlying Underlying Cause Underlying Underlying Cause Underlying Unde Due to (or as a consequence of). for use as the burial-transi Hepatoma MKNOVM and that initiated events resulting in death) Last Due to (or as a consequence of): physician lopath Mkinum Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant Baldwin 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 4 Pregnant : 9 Unknown Pregnant at time of death 1 Yes 2 L 9 Unknown the detached ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ы сеплисате has been signed director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Cirrhosis 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown chronic Kidney disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 12 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier 📉 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Number Practioner: To the best of my knowledge death occurred at the time, date and place and due to the cause(s) and manner as etaled. (Check To the 29b. Signature and title of Certifier 29d. Date signed (Month. Dav. Year) D0065471 October, 24, 2010 MP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chesa peake Drive, Bel Air, Maryland 14 RIFISHER, MD 500 UPPLI 31. Date filed (Month, Day, Year) OCT 282010 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Darrell Buroughs Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Darrel1 Burroughs Day Medical Examiner 1809 hrs Darrell Buroughe October 25, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital Baltimore NA 5. Social Security Number 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) **Funeral** Director Months Days Hours Min 212-33-8795 19 1 XM 2 F 04 - 30 - 91Country) MD Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 X Yes 2 No MD NA items 23a or 28a-f shoust be notified at once. Baltimore hours after death with the Maryland Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2634 East Biddle Street 21213 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. African 1 X Never Married 2 Married Yes 3 Widowed Yes, Give Year Yes 2 No specify: Divorced Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene.
Department of Health and Mental Hygiene. It item 27 is marked other than "natural"; injury or other traumatic event, the Medical Examiner. Specify: American ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10th Grade NA Laborer various trades 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Melvin D. Burroughs Melissa Grissitt 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melissa Redding-Mother Biddle Street Baltimore, 2634 Ε. MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Baltimore, MD Western Star Cem 11-02-10 Donation 5 Other Specify. 22. Name and Address of Facility 21. Signature of Funeral Service bicensee Wylie Funeral Home P.A. Baltimore Street Gilmor Gilmor MD 2121 A proximate Interval Part I. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause of each line /Medical Death a. Gunshot of Head Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 butus after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Physician/Medical AMENDED #1 per me, g908, 10/29/2010dhbUNPENDED Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Year Fetal death Month Day past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≦ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ✔ ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other DOA 1 🗸 Yes ပ္ 28a. Date of Injury (Month, Day Year) Oct 25, 2010 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Subject shot 1735 hrs Natural 1 Yes 2 ✔ No 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 1200 N Milton Ave, Baltimore, MD determined (Specify) Steps 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 26, 2010 30. Name and address of person who completed cause of death (Item 23a)

State 31. Date filed (Month, Day, Year) Registrar OCT 28 2010

Patricia Aronica-Pollak MD.

32. Registrar's Signature

Assistant Medical Examiner

**ORIGINAL** 

111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 OCME 2006

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760,

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a filed within 72 hours al Hygiene. other than "natural", vent, the Medical Ex-	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Decedent's Us	ual Occup	ation	kina	16b. Kin	nd of Business	/Industry				
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he de	ysic	1 □Yes 2 □No 9 □ Unknown	4 □ Pregnant at time of of the state of the											
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To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the fu		(Check only 2 Medical Exan	nysiclan: To the best of my kno niner: On the basis of examina and manner stated.											
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Star Registra		31. Da OCT (M218 2010)	32. Registrar's Signa	ature										

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 25 per verb., g908 10/28/2010dbb
Reg. No. 33807 Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 06:04 AM Donald Luther Beers OCTOBER 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE TOWSON SAINT JOSEPH MEDICAL CENTER 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 8. Date of Birth Funeral 1 🂢 M 2 🗆 F Months Days Hours Min 0270471948 Country) Maryland 63 **Director** 216-56-3470 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No MD Baltimore Baldwin 10e. Street and Numbe 10f. Zip Code ò 10g. Citizen of What Country? 23a Funeral 13214 Fork Road 21013 U.S.A. items 2 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 14. Race - American Indian, Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc. Armed Forces:

1X Yes 2 No
If Yes, Give Vietnam
Year or Dates. Era Black, White, etc. þ 1 Never Married 2 XMarried "natural", or 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Divorced 4 Divorced White event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Carpenter Self-Employed Be 17. Father's Name (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Surname) ည Luther W. Beers Mildred E. Hamilton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 Page 1 and 2 Mary C. Beers 13214 Fork Road - Baldwin, Maryland 21013 (wife) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or otl Date cemetery, crematory or other place, 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 10/26/2010 | Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. assa 11750 Belair Road - Kingsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ESOPHAGEAL CANCER Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Completed by Physician/Medical death certificate be Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown P.0. ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? RESPIRATORY FAILURE Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? ISCHEMIC BOWEL 24a. Was an page 2 performe LACTIC ACIDOSIS 1 Yes 25. Was case referred to medical examiner?
1 Yes 2 No **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Hospital or Attending injury 5 Pending 24 hours after death. Funeral Director: A Accident Investigation completed filled in by the 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 31826 مانند 10-26-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21204

DHMH 17 Rev 7/2009

State

Registrar

RICHARD L. LINTHICUM

OCT 28 2010

31. Date filed (Month, Day, Year)

Registrar's Signatur

7601 OSLER DRIVE TOWSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 20 9:30 AM Gary Edward Burnham Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Laurel Regional Hospital Prince Laure George's Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months Days (Month, Day, Year) March 13,1944 1 🖾 M 2 🗆 F Hours Min. 134-34-1870 66 Yrs. **Director** NY Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after deau man was tractioned from to fleath and Mental Hygiene.
Thent: If item 27 is marked other than "natural", or items 23a or 28a-f show that: If item 27 is marked other than "natural", or items 23a or 28a-f show that: If item 27 is marked other than "natural", or items 23a or 28a-f show that it is a went, the Medical Examiner must be notified at 23a or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Prince George Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8709 Crystal Rock Lane 20708 IISA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc. 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Contractor Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Martha Mikret Roy W. Burnham, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 8709 Crystal Rock Lane, Laurel, MD 20708 Joan M. Burnham/ 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot October 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State Ivy Hill Cemetery 2010 Laurel, MD 4 Donation 5 Other (Specify) permit. 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityDonaldson Funeral Home, M01053 313 Talbott Ave., Laurel, MD 20707 at 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequ **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed lifted in by the Innertal Innertal rescue, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Year 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 1 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2  $\square$  No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature nd title of certifie 29d. Date signed (Month, Day, Year) DU067210 10/2/10 ddress of person who completed cause of death (Item 23a) (Type, Print) 7300 Van Dusen Road 30. Name and Laurel Regional Hospital

State Registrar

DHMH 17 Rev 7/2009

Box 68760°

P.O. |

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) co Physician/ UP Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Seasons Hospice Randallstown g. Birthplace (State or Foreign Country) Pennsylvania If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. 1 🕅 M 2 🗆 F Months Days Hours Director 577-44-3191 10, Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Examiner must be notified at Funeral Director 1 ☐ Yes ŽXX No Columbia MD Howard 10f. Zip Code 5 10e. Street and Number 10g. Citizen of What Country? 23a USA 9243 Feathered Head permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muonce. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces'

1 X Yes 2 If Yes, Give
Year or Dates. Black White, etc. ð 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White 3XXWidowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Specialist Check Claims Unknown Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Barbara Godash John Bodolie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Feathered Head, Columbia, MD 9243 Ronald P. Bodolay / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 □ Cremation 3 □ Removal from State Elkridge, MD 10/30/2010 Meadowridge Mem. Pk 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home, Laurel, MD 20707 M01103 313 Talbott Avenue, Part 1. Inter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or high ratifallure. List only one study on each line. 23a. Part 1. Approximate Interval Between Onset and Death Immediate C se (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list or ditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş Q 1 Tes 2 No 3 Probably 4 Unknown Division of Vital Records, Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No After this certificate 1 Tyes Yes 2 25. Was case referred to medical examiner?
1 ☐ Yes 2 ► No 26. Place of Death (Check only one) Hospital: Other: မ 4 Nursing Home 5 Residence 6 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Denth 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident Investigation within 24 hours after death To the Funeral Director, 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or investigation is an examination of the cause of examination and/or investigation is an examination. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type

State Registrar 31. Date filed (Month, Day, Year)

28

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. Ne Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 1855 PM october Sidney Albert Brodie 20 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Agnes Hospital Raltimore N/A If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1**X** M 2□ F 87 11/13/1922 N. Carolina Director 229-22-9864 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits 10a. State ral", or items 23a or 28a-f show Exuminer must be notified at 1XYes 2 No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4 S. Ellamont St. 21229 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married r than "natural", or 1 ☐Yes 2 No 2 If Yes, Give Year or Dates: Specify Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 8th Grade College (1-4or 5+) Construction Worker Roy Kirby& Sons Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nedham Brodie Carrie Nicholson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and :
Department of Health
Important: If item 27
any injury or other tr.
once. Bernard Brodie(son) Bernice Ave., Baltimore, MD 21229 S. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison FOrest 10/28/10 Baltimore, MD Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 21. Signature of Funeral Service Licensee (liam) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final nspigation pneumonic **Physician** Day disease or condition resulting in death) 3 Days Small bowel Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner 4 cute gengl attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical Colonaly IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day signed by the aid be detached for 5 Other (specify) 1 □ Yes 2 □ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabeter Mellity 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 2 ☑ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☑ Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760. Vital Records, of Division e Funeral within 24 hor To the Fune completely fi

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

State DHMH 17 Rev 1/2001

Registrar

Ming

29b. Signature and title of certifier

HS1-

and manner stated.

P 23496

29d. Date signed (Month, Day, Year)

2010

Uctober 20

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

istor any,

Wang

South Caton Avenue, Baltimore 900

istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September Day 30. 2010 Francis B. Bell 7:40 AM M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Baltimore Timonium Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral 1 X M 2 🗆 F Months Days Hours Min May 12, Ye Pennsylvania 1918 **Director** 216-12-7294 92 Usual Residence of Decedent unk 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland at 10d. Inside City Limits Director PA notified McVeytown 1 Yes 2 No McVeytontown MD 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Examiner must be Funeral 23a 17051 USA P.O. Box 397 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Arreed Forces?

1 2 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married ō 72 hours after Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: If Yes, Give 43-45 Specify white "natural" 3X Widowed 4 □ Divorced Year or Dates. It of Health and Mental Hygiene.
If item 27 is marked other than "natur or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 Page 1 and 2 should be filed within ment of Health and Mental Hygiene. College (1-4 or 5+) machine repair Martin Marietta Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Pearl Alexander Ralph Bell 19a. Informant's Name/Relationship (Type, Print)
Nancy Heinold/daughter 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 809~Bradshaw~Road~Po~Box~24~Upper~Falls, MD <math display="inline">21156Important: If item any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) Si naturi et Euneral Servi e Licen Roma I d State Andremy Board 655 W. Baltimore Street Drirector MD21201 Baltimore, Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on such line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 100 Medical Due to (or as a cor equence of: **Examiner** 192 Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence that the death certificate be executed and use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant : 9 Unknown Other (specify) Pregnant at time of death 1 Yes 2 L 9 Unknown Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by director, page 2 should be The law requires Records, 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 1 ☐ Yes 2 ☎ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifics completed filled in by the funeral director, to Be 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Day, Year) 29b. Signature and title of certifier 29d Date signed (Month, D. September 29c. License number 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY ROAD ERNESTINE WRIGHT, M.D. TIMONIUM 21093 MD31. Date filed (Month, Day, Year) Registrar's Signature State OCT 28 2010 Registrar

DHMH 17 Rev 7/2009

SEPTEMBER

BELL, FRANCIS

State

Registrar

31. Date filed (Month, Day, Year)

OCT 28 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death James Omer Cullings 3. Time of Death Physician/ October 25, Day 2010 2:15 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 1108 Middleborough Road **Baltimore** Social Security Number 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign MC ountry) **Funeral** 1 XXM 2 🗆 F Months Days Hours May 23, 1939 Director 214-36-7736 71 Usual Residence of Decedent 28a-f show ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD **Baltimore** Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1108 Middleborough Road 21221 U.S.A. 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ 1 Never Married 2 Married Yes, Give XX Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNO Specify: Specify: White Completed 3 ☐ Widowed 4 XXDivorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Postal Service Postal Delivery permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other tany injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Omer Cullings Elizabeth Shauck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 509 Holden Road Towson, MD 21286 Eric Cullings (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 XX urial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) 10/30/10 Druid Ridge Cemetery Pikesville, MD 21. Signature of Funeral/Sevice Burgee Henss Seitz Funeral Home, Inc 3631 Falls Road Balto, MD 21211 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. 23a. Part 1. Enter the disea Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, it any, leading to in neciate cause. Enter Underlying Examiner -transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and Due to (or as a consequence of) resulting in death) Last the burial the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy completed filled in by the funeral director, page 2 should be detached for in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 robably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? ₹4a. Was an 24 hours after death. e Funeral Director: After this certificate has I performed 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Hospital 2 XNo Other: ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 ☐ Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, To the 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day,

Registrar
DHMH 17 Rev 7/2009

State

ass of person who completed cause of death, (Item 23a) (

28 2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Philip Chiappisi 2010 8:500 october /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ba 1timore Agnes tospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** 92 Days Hours Min 1**∑**M 2□F 100-07-4114 Director 10/6/1918 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show of 2 should be filed within 72 hours after death with the Maryla thand Mental Hygiene.

27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with the Hygiene. 21228 **USA** 709 Maiden Choice Lane Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 XYes 2 □ No If Yes. Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 □Yes 2 No If Yes, Give Year or Dates Specify Specify þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Borough Engineer Public Power Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any injury or exercise. Accursia Puccio Antonio Chiappisi 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7309 Marbury Road, Bethesda, MD 20817 Carolea Logun / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans 10/28/2010 | Crownsville, Maryland 21. Signature Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part1. Eater the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** ongestive tear /Medical Due to (fr as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) signed by the aid be detached for 1 ☐Yes 2 ☐ No o a Unknown g 
Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performed? certificate 2 1No 1 ☐ Yes 2 ☐ No 1 □Yes Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 10 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred al or Attending F after death. 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) , MO 44377 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Caton Deneen Bowlin 900

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

OCT 28 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death В. Physician/ Lenuel Collins Month 2010 October <u>/:</u>50 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Cherry Lane Nursing Center Prince Goerge's Laurel Social Security Number 057-42-4772 8. Date of Birth (Month, Day, Year)
Nov.8,1950 If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 🛛 M 2 🗆 F Months 59 Director Usual Residence of Decedent 28a-f shor 10b. County the Medical Examiner must be notified at Director 10a, State 10c. City, Town or Location 10d. Inside City Limits MD Howard Laurel 1 Yes 2 No 9 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 9333 Cabot Court 20723 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. o, ģ 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Completed Black Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Manager Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ B. Collins Irene Burney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9333 Cabot Ct., Laurel, MD 20723 Robena Collins / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final 10/26/10 Journey Crem Woodbine, MD 22. Name and Address of Facility
Maryland Cremation Services
PO\_Box\_1413, Baltimore, MD 21. Signature of Funeral Service Licens eDorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Ver Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year been signed by the a 9 Unknown 9 Unknown P.0. Part II. <mark>Other significant conditions</mark> co<u>nt</u>ributing to death but not resulting in∡the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the lirector, page 2 s autopsy performed? Yes 2 No 2 🗌 No 1 🗌 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending s after death.
I Director: Aft 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Records, Division of Vital 24 hours a Hospital сотрыете within 2 To the 1

> State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print)
YED SADIQ MID 14333 LAYREL-BOWJERD LAUREL, MD 20708

2 Medical Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Thelma Elizabeth DeBoy Medical M A 60P Octobe 2105 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Agnes Hospital Baltimore . Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea March 7, 1 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 F Director 212-22-6355 Country) 83 Usual Residence of Decedent or 28a-f show 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Baltimore 1 ☐ Yes 2 1 No Catonsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 715 Maiden Choice Lane CR515 21228 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🖾 No λq 1 Never Married 2 Married Black, White, etc. Maryland 21215-0036 If Yes, Give Year or Dates Completed 1 ☐ Yes 2 ☐ No Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Merson Hefner Lillian Dreyor permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m any injury or other traum: once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Janice Tucker</u> Daughter 2429 Forest Hill Road; Marriottsville,MD 21104 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Loudon Park Cemetery 10/28/2010 4 Donation 5 Other (Specify) Baltimore, MD Funeral Service I) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 630 Edmondson Avenue: Catonsville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical minutes Examiner ischemic cardiomyopath Due to (or as a consequence of) Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury anding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? COPD Completed 1 Yes 2 No 3 Probably 4 Unknown Chronic Kidney disease and stage Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy perform 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 1 Natural 28b. Time of 28c. Injury at Hospital or Attending 28d. Describe how injury occurred 5 Pending work?
1 Yes 2 No Accident Investigation completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowled e death occurred at the film, date and place, and due to the cause(s) and manner stated. To the within 2 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) october 23 2010 dress of person who completed cause of death (Item 23a) (Type, Print) Myla Our parter 711 Maiden Choice In Catonsville MD MD 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year Day **Physician** Daniel Byron Evans, Sr. AM 0745 October 2 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SAINT BALTIMORE AGNES If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Oct. 5, 9. Birthplace *(State or Foreign Country)* **Pennsylvani**a 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1 X M 2 □ F 200-26-6420 75 Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 21K No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 6 Forest Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify. þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Systems Engineer Defense 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Byron Evans Anna Violet Cassebaum ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Forest Drive: Catonsville, MD 21228 Ruth A. Evans Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Crest Lawn Mem.Garden:10/26/2010 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Sign sure of Funeral Service Licensee 7 1630 Edmondson Avenue; Catonsville 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HYPOTENSION disease or condition resulting in death) Due to (or as a consequence of) ONAR Se wentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine CHRONC KI resulting in death) Last Physician/Medical ARDIDMYOPA IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □Yes 2 □ No 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division of Vital Records, P.O. Box 68760 EVANS, DANIE!

Hospital or Attending Physician: The law requires that the death certificate be executed

Items 23a or 28a-f show

event, the Medical Exeminer must be notified at

٥,

"natural"

Department of Health and Mental Hygiene. Important; If item 27 is marked other than any injury or other traumatic event, Inc. Magnee.

**Physician** 

/Medical

Examiner

the burial-transit

physician

attending ph for use as th

cate has been signed by the page 2 should be detached

certificate

this

After t

funeral director,

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

within 24 hours after death

To the Funeral Director:
completely filled in by the

Registrar

MDHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier Soften MD

(Check only

3449 WILLCONS AVENUE SUITE 300 BALTIMORE, MARTYLAND 32. Registrar's Signature

ATTENDING

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CARDIOLOGIST

29c. License number

MARYLAND

State Registrar

DHMH 17 Rev 1/2001

South Charles

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 601

efferra

32. Registrar's Signature

Gleta Chew

31. Date filed (Month, Day, Year)

282010

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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			1 - State Registrar	Certificate of Death Reg. No. 2 0 1 0 2 2 0									22010		
			Decedent's Name (First, Middle, La	,						2. Date of Death 3. Time of Death					
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	Funeral		5. Social Security Number 6. 5	Sex 7. Ag	e (In yrs. I	ast birthday)		r 1 Year	If Under		8. Date of Bir	th			place (State or Foreign
	Director		217-24-5229	I □ M 2 🗶 F	8	0_ Yrs.	Months	Days	Hours	Min.	(Month, Da March	5, Year)	930	Cou	Kentucky
	» A	] .	Usual Residence of Decedent  10a, State 10b, County												_
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	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho er than Medical Examiner must be notified at		11. Marital Status	12. Was Decedent Armed Forces?			Vas Deced Yes, spec	dent of His cify Cubar	spanic Orig n, Mexican	gin? (Spe ı, Puerto	cify Yes or No- Rican, etc.)			e - Ameri k, White	can Indian, etc.
36	after Il", o <b>xam</b>	db	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2X☐ If Yes, Give	No	1	☐ Yes	2 <b>X</b> No	Specify:				Specify:		
21215-0036	atura cal E	Completed	15. Decedent's	Year or Dates.		16a. Deced	antie Heur	al Occurs	ation			401-14			
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D	led w Hyg othe	Be	17. Father's Name (First, Middle, Last)			· · · · · · · · · · · · · · · · · · ·	LULU	<u> </u>	18. Mothe	er's Name	e (First, Middle,				
lan	be fi ental rked ic ev	은	Corbett Farl	,				ı	Edith Test						
Maryland	2 should be filed within 72 hours aft. It and Mental Hygiene. 27 is marked other than "natural", traumatic event, the Medical Exat		19a. Informant's Name/Relationship (			19b. Mailin	a Address	(Street a	nd Numbe	er or Rura	l Route Numbe	er, City or Town, State, Zip			Code)
	and 2 st Health a tem 27 is		Deborah C. G	Tool maning					Collier Lane, B					land 21017	
ē,	e 1 and of Heal If item	- 3	20a. Method of Disposition			Place of Dispos	sition (Nar	ne of			Date				own, State
Ë	Page nent c ant: If ury or		1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec			emetery, crem . Carme	-			10-2	7-10	Ba	ltim	ore	,Maryland
Baltimore,	二 草 色 语		21. Signature of Funeral Service Licer		1110	22	Nome or	d Addros	o of Engilit						
ä	permit Depar Impor any in		michael Phy	asser Plan		60	ловн	arfo	ord I	Mar Roac	izulle.	Fui	nera re.M	ll C larv	hapel 1214. Tand21214.
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	Physician/		shock, or heart failure. List only inmediate Cause (Final				1%		10		5			١.	Interval Between Onset and Death
	Medical		disease or condition resulting in death)	a. Chroni	a consequ	lence off:	14-21	VE	40M	vane	NY U	150	1286	- 1	March 2010
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		пē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequ	uence of):								_	= = = = = = = = = = = = = = = = = = = =
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09	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	dical		d											
376	ficate g phys as the	Ned	le eeu e					-				-			
99	attending p	Jun 1	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 Live Birth			Estopio	rognana	,			- 1	23d. Dat	e of deliv	very
Box 687	leath e atte d for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 🌠 No	4 Pregnant a			Other (sp		<i>y</i>				Mor	nth	Day Year
O. F.	that the degreed by the greet detached	څ	9 Unknown	9 Unknown											
P.O.	es that igned l	<u>م</u>	Part II. Other significant conditions contributing to death but not resulting in the un					inderlying cause given in Part I. 23e.			23e. Did to	Did tobacco use contribute to the cause of death?			he cause of death?
JS,	requires been sig should b	Completed by								1 ☐ Yes 2 ☐ No 3औ Probably 4 ☐				bably 4 🗆 Unknown	
0	w rec	ᢛ	[ ]								24a. Was		24b. V	Vere auto	ppsy findings available ompletion of cause of
Sec.	The law ate has page 2 :	틍										rmed?	d	eath?	2 D No
표	ician: The certificate 'ector, pag	BeC	25. Was case referred to medical		26. Place of De				ce of Deat	1 ☐ Yes of Death (Check only one)			)	□ res	2 LJ NO
Žį.	ysician: is certific director,	10 B	examiner? 1 <b>Љ</b> Yes 2 ☐ No	Hospital:	ent 2 🗆	ER/Outpatient	3 🗆 DO	Othe	r.			lence 6	□ Othe	r (Specif	v)
of	g Physer this neral di		27. Manner of Death	28b. Time of injury		8c. Injury	at		Home 5 № Residence 6 □ Other (Specify)  28d. Describe how injury occurred						
u	Attending Phy cleath. ctor: After this y the funeral o	ica	1 █ Natural 5 ☐ Pending 2 ☐ AccidentInvestigatio		, rear)	injury	м	work?	yes 2□	No					
Division of Vital Records,	I or Attending after death. Director: After d in by the fune	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Hornicide determined	28e. Place of Inju- building, etc	iry - At ho	me, farm, stre	et, factory	, office		:				r or Rura	l Route Number,
Ö	talon rsaft al Di			Danialing, etc	. (Opcony,					_	City or Tow	n, state,			
	To the Hospital or Atter within 24 hours after de To the Funeral Directo completed filled in by the	Medical	29a. Certifier 1 Certifying Phy (Check 2 Medical Exam	sician: To the best of	my knowl	edge, death of	ccured at	the time,	date and p	olace, and	d due to the cau	use(s) ar	d manne	r as state	ed. luse(s) and manner stated.
	the H nin 24 the F	ĕ Z	only one) 3 A Gertifying Nur	se Fractionen To the	best of my	r knowledge, de	setti icocur	ned at the	thre, data	and place	s, and due to the	cause(t	, and due I, and mai	mer at t	idec.
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			GIV, Comp					RIa	580	80		10	27	10	
Y			30. Name and address of person who	•	•		int)		_	^	1 51	7		a 1.	hoeleuw.
<u></u>			Annelewis VILLA				N.	Char	Les	8P~	et, Ste	410	5,6	54 Ho	LOGIEDAN.
	Stat Registra		31. Date filed (Month, Day, Year)	32/Registra	ır's Signat	ure &	No. 1								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ FINE DA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Can 5. Social Security Number Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday Funeral 1 M 2 F Days Hours (Month, Day, Year) 8 Director 213-10-8246 MD Usual Residence of Decedent 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location Director 1 Yes 2 X No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3217 MARNAT ROAD 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by Yes 2 X No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced WHITE Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 12 OFFICE MANAGER REAL ESTATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ MORRIS RUDOLPH MINNIE KAPI.AN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANET KOTELCHUCK/SISTER 3228 MARNAT ROAD, BALTIMORE, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 2 Cremation 3 Removal from State ARLINGTON CHIZUK AMUNO 10/28/2010 BALTIMORE, MD 5 Other (Specify) Donatio Signature of Fu 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD Part 1. Enter the disease, or an plications that caused the shock, or heart failure. List only one cause on each line. eam. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events To Be Completed by Physician/Medical Examiner Due to for as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed F. Arillatie Due to (or as a consequence of) resulting in death) Last Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Year Day Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autons 1 ☐ Yes 2 ☐ No Yes 2 - No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospita 1 🗌 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes injury 5 Pending 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral D Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

OIA COURT

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2010 40 pm EUGENE Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Social Security Number LAUREL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth
(Month, Day, Yea
JUNE 1 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months Director 1934 JUNE 213-30-4026 76 Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at or 28a-f shov 10a. State 10c, City, Town or Location Director 1 Yes 2 No PRINCE GEORGE'S LAUREL 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code - APT. 20707 7901 LAUREL LAKES CT. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 BLACK 1 Yes 2 XNo If Yes, Give Year or Dates 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) S. GOV'T 12TH LABORER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOHN WESLEY GREEN EDNA M. PRICE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7901 LAUREL LAKES CT. - APT. #305, LAUREL, MD EUGENE GREEN, JR./SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/01/2010 | CROWNSVILLE, MD CROWNSVILLE 21. Signature of Funeral Service Licensee 22, Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 2007-09 EASTERN AVE., BALTIMORE, MD Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cancer disease or condition resulting in death) Medical Due to (or as a c nsequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or iinjury Examiner Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-tran that initiated events e to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 1 Yes 2 g Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has performed
1 Yes 2 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 2 No ၉ 1 Tes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation within 24 hours after deatl To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c, License number 10, 20, 2010 Karunwi N68782 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sportal 7300 Van Ausen Rol Law-el My

DHMH 17 Rev 7/2009

State

Registrar

filed (Month Day, Year)

OCT 28

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FREDERICK Month GREENHALGE 09:32 AM OCTOBER 2010 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A HARBOR HOSPITAL B BALTINOR | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth | Months | Days | Hours | Min. | Aufgenth, Pay, Year 52 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F 58 Massachusetts 011-44-3740 **Director** Usual Residence of Decedent or 28a-f show th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a -f shov traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 🗆 Yes 2 💆 No Baltimore **Baltimore** MD 10f. Zip Code 21227 10g. Citizen of What Country?
United States 10e. Street and Number Funeral 3204 Elizabeth Avenue filed within 72 hours after death with Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Printing Offset Stripper and Mental Hygien Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ethel Collins ည Carroll Greenhalge pe 1 and 2 should b of Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3204 Elizabeth Ave., Baltimore, MD 21227 Summer Greenhalge - Wife permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Ponation 5 Other (Specify) West Arundel Crematory 10-26-2010 Glen Burnie, MD Signatured Funeral Servi 2. Name and Address of Facility Ambrose Funeral Home, Inc 1328 Sulphur Spring Rd., Arbutus, MD 21227 2. Name and Address of Facility Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line SEPSIS Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner MISEASE WITH CIRRHOSI LCOHOL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of, burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last CUTE CI and attending physician Physician/Medical certificate be Box 68760 as the l IF FEMALE: use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Fetal death The law requires that the death for in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Pregnant at time of death 1 Yes 2 L the g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 No 3 Probably 4 Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes has To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate i completed filled in by the funeral director, page 1 Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 1 Yes 2 No 5 Pending Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) OCTOBER. 24,2010

Registrar

NV DHMH 17 Rev 7/2009

State

3001 SHANOVER ST

32. Registrar's Signature

BALTIMORE

21225 MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VERNA

SOURABH

31. Date filed (Month, Day, Year)

OCT 28 2010

## State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Galloway Annie 10 October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Rock Glen Nursing Center NA Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country), N C 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours Min Months 214-22-0468 88 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits notified at Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or amy injury or other traumatic event, the Medical Examiner must be rone. Funeral 2213 W. Lexington Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Galloway 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etcAfrican Armed Forces? 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: American 3 ₺ Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 11th Grade College (1-4 or 5+) Head Gear Company Tailor Annie Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Galloway Mimie Cardwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah Thomas-Niece 2213 W. Lexington Street Baltimore, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Woodlawn Cem. 1 X Burial 2 Cremation 3 Removal from State 10-30-10 Woodlawn, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licensee 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph. sician/ metactobie disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Yes 2 No 9 Unknown 3 Ectopic pregnancy for Pregnant at time of death 5 Other (specify) the 9 🗆 Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed I page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an autopsy this certificate 24 hours after death. Funeral Director: After this certific, leted filled in by the funeral director, it 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No ER/Outpatient 3 DOA Certificate: To 1 Inpatient 2 I 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) To the 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 10.25.10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

10:15A

1XXYes 2 □ No

Onset and Death

Day

7/201

months

Year

Registrar DHMH 17 Rev 7/2009

State

821

32. Registrar's Signature

457

N. EUNEW

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 toward

R

31. Date filed (Month, Day, Year)

OCT 28 2010

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Balkiners.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 5139AM Shirley Gibson CROSER 25 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NA BALTIMERE ST. ACNES If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01-20-38 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2X F 71 212-36-6835 MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. nt: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County ural", or items 23a or 28a-f show Examiner must be notified at XIXYes 2 □ No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 226 Mallow Hill Road 21229 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc.African 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: American <u>م</u> 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation traumatic event, the Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Home maker 8th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carter Ida Lee 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and Department of Health Important: If item 27 any injury or other tn Russell Gibson-Son 226 Mallow Hill Road Baltimore, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion Cem. 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 11-02-10 Lansdowne, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD 21217 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ach line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or s a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical ası IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of certificate has I death2 1 ☑ Yes 2 ☐ No 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 은 After this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury 1 Tes 2 No 2 Accident investigation within 24 hours after death To the Funeral Director; Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)
OCT 28 2010
Lenus S. Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**Examiner Funeral** with the Maryland or than "natural", or items 23a or 28a-f show Hygiene. other than "natural", or i Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygin Important: If item 27 is marked other any Injury or other traumatic event, III

**Physician** 

/Medical

Box 68760. P.O. Records, certificate Division of Vital this

Director Usual Residence of Decedent 10d. Inside City Limits 10a. State WV 1 Yes 2 □ No Director 10e. Street and Number 511 B Broadway Avenue 26301 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 XNo If Yes, Give Year or Dates 1 ☐Yes 2 No Specify: White 3 Widowed 4 XDivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Journalist Newspaper/Press 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ε. Guy Sprouse Muscar Rose ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Kissling/Daughter 1318 Lone Pine Trail, Severn, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/26/2010 Final Journey Crem. Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21. Signature of Funeral Service Licensee Dorota Marshall Marshall 23a. 111. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 ☑No Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2000 2 🗆 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes 2□√0 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Deal 28a. Date of Injury 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1-Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours e Funerai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my opinion, death accurred. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #18 Per FH G908 10/28/10 JH State of Maryland / Department of Health and Mental Hygiene 20 10 33826 State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ october 22, 2010 KENNETH SHEVER GIRARD 3:31 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE TOWSON 305 EAST JOPPA ROAD, #505 Birthplace (State or Foreign Country)

MO 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number 6. Sex 8. Date of Birth 1.□ M 2 □ F Hours 0771071953 Director 246-72-9869 57 MO Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director ms 23a or 28a-f s must be notified 1 Yes 2 No MD BALTIMORE TOWSON 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? iral", or items 23a Examiner must be Funeral 21286 USA 305 EAST JOPPA ROAD, #505 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 🛣 Never Married 2 ☐ Married Page 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or 1 ☐ Yes 2X No If Yes, Give altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐X No Specify: WHITE Specify: Completed 3 Divorced 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) COUNSELOR HEALTH CARE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Shever HERBERT GIRARD PHYLLIS SHEZER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANKLIN STREET, UNIT 309, ANNAPOLIS, MD 21401 MARYLIN ROBINSON/SISTER 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HILLTOP SERVICE CORP.: 10/27/2010 TOWSON, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) Day 4 Pregnant
9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has autopsy perform Yes 2 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🕊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registra

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

29c. License numbe

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Maryland 21215-0036

Baltimore,

Box 68760

P.0.

Records,

**Division of Vital** 

ORIGINAL

32. Registrar's Signature

Hoff

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, neral Director: / filled in by the fi 24 hours

1 - For State Registrar

**Physician** 

/Medical

**Examiner** 

1. Decedent's Name (First, Middle, Last)

lorence

4a. Facility Name (If not institution, give street and number)

Old

 Birthplace (State or Foreign Country) 10/29/1916 PA 10d. Inside City Limits 1 □Yes 2 □ No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. WHITE Specify: 16b. Kind of Business/Industry OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) ROTHSTEIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3708 BRETON WAY, BALTIMORE, MD 20c. Location - City or Town, State BALTIMORE, MD SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Pulmonary Disease 20 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 ☐ Yes 2 ☑ No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 \sum Nursing Home Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) 27. Manger of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 000 2512 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 310 BNGK 301 2 SUSUC BCE 31. Date filed (Month, Day, OCT 28 32. Registrar's Signature Year State 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

4b. City, Town, or Location of Death

MD

Date of Death 10/24/2010

21208

4c. County of Death

BALTIMORE

3. Time of Death

10

Amend Item 2 State of Maryland 10 Page 12010 and Health and Mental Hygien & Certificate of Death Reg. No.

perger

500

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 100m25-20 Pe Hilda V. Hedrick 3:20 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore 5. Social Security Number Birthplace (State or Foreign Country) MD If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Days Hours 1 □ M 2 🗓 F 218-14-8453 06-11-21926 84 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2ሺ No Harford Bel Air MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21014 USA 402 C Aggies Circle permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White 3 ₺ Widowed 4 □ Divorced Specify: Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Hilda Brent Clarence Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 664 Cherry Hill Rd Street, MD 21154 William E. Schilling Jr (POA) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 10-29-2010 Baltimore, MD Moreland Mem. Park 4 Donation 5 Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of Inc 610 W. MacPhail Rd Bel Air, MD 21014 Signature of Funeral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) LUNG CANCER Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed ete has keen signed by the attending physician and page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificate Yes Division of Vital ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗶 No Other: 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Accider Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State To the Hospital o within 24 hours af To the Funeral Di completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tite 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

JACKIE JONES,

Date filed (Month, Day

28

OCTOBER

H. VIDA HEDRICK

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

person who completed cause of death (Item 23a) (Type, Print)

CRNP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G909 11/01/10 JH
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 6:350M Howe Medical Name (if not institution, give street and number) Town, or Location of Death Examiner 4c. County of Death Hi More 9. Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 KF Months Hours Min **Director** show 10a. State 10b. County City, Town or Location filed within 72 hours after death with the Maryland notified at 10d. Inside City Limits **Funeral Director** Battimore 1 Yes 2 No 28a-f 10f. Zip Code ō 10g. Citizen of What Country? ıral", or items 23a oı Examiner must be 21212 teoraes 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT Elementary/Seconday (0-12) College (1-4 or 5+) sabilit Hamir permit. Page 1 and 2 should be filed wit. Department of Health and Mental Hygier Important: If item 27 is marked other t any injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last) မ me/Relationship (Type, Print)
W. Harker 20a. Method of Disposition 20b. Place of Disposition (Name of Date Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) . Signature of Funeral Service Lice ess of Facility : 21212 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. tens that caused the death. Do not enter Interval Between Onset and Death Immediate Cause (Final Physician/ Acute disease or condition resulting in death) mouth Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to humodiate cause. Enter Underlying Cause (Disease or linjury Examiner Directo for as a consecution of the been signed by the attending physician and should be detached for use as the burial-transit or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an after death.

Director: After this certificate has the contract of the contrac performe 2 M No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No 은 1 🗌 Yes 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: Manner of Dea h 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital or within 24 hours ar To the Funeral D Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatu 29c. License number PD1.02 27 2010 0/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MIES MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene [ ] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4b, City, Town, or Location of Death Examiner 4c. County of Death 1timor If Under 24 Hrs Hours Min. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🕽 Months Days Month, By, Ye **Director** Carolina Usual Residence of Decedent or 28a-f shov 10a. State 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at **Funeral Director** 10d. Inside City Limits 1 Yes 2 No timore 10g. Citizen of What Country? Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than College (1-4 or 5+) Elementary/Seconday (0-12) the Be 18. Mother's Name (First, Middle, Maiden Surname, th and Mental H

27 is marked of

traumatic ever မ Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other trau once. Brown nnox 202 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee NO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of Jing, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Phumonia Medical Due to (or as a consequence of) **Examiner** Seizuves days Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last the bunial-tran Due to (or as a consequence of): ate has been signed by the attending physician page 2 should be detached for use as the bunal. Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live Tetal down
Pregnant at time of death
Unknown 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by prior stroke, dysphagia, chronic 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? breast cancor 24a. Was an autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No Yes 2 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Yother (Specify) HOSPICP 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Deat Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or investigating it as a stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 0070635 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Putel 4105 aura 6701 N Charles 31. Date filed (Month, Day, Year)
OCT 28 2010 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

10-08114	
Monta Hunt	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death Physician/ 3. Time of Death Month Day October 23, 2010 **Medical Examiner** 1553 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Baltimore** University Hospital 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9 Birthplace (State or **Funeral** oreign Director 217.08-1628 01 Usual Residence of Deceden Oh Count IOc. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 9 awrence vill Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23s or 28s-f sho rother traumatic event, the Medical Examiner must be notified at once. Director 10g, Citizen of What Country? 30044 USP tark Funeral 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-Race - American Indian, Black 1 Never Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 Married 2 No Yes f Yes, Give Year or Dates: 4 Divorced Yes 2 No specify: Specify: Ы \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NQT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) *lerator* ather's Name (Eirst, Middle, Last 18.Mother's Name (First Middle, Maiden Surname Be one ို 19b. Mailing Address 20b. Place of Disposition (Name of cemetery 2 Premation 3 Removal from State Donation 5 Other Specify: Signature of Fug ral Service Licens 22. Name and Address of I Nat 23a. Part I. Enjerthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval **Physician** Between Onset and /Medical Death a. Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last death certificate be executed attending physician and or use as the burial - tran Physician/Medical UNPENDED AMENDED Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth Day 3 Ectopic pregnancy Fetal death Month Year past 12 months? Pregnant at time of death Other (Specify, 1 Yes 2 No 9 Unknown Unknown ched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ö ş α. 1 Yes 2 No 3 Probably 4 Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of perform death? page ✓ Yes 2 No 2 No 1 Yes the Hospital or Attending Physician: Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other Nursing Home 5 Residence 6 Other Inpatient 2 V ER/Outpatient 3 OOA 1 Yes ٥ ğ 28a. Date of Injury (Month, Day Year) Oct 23, 2010 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: Subject shot Natural 1517 hrs Division Pending 1 Yes 2 ✔ No the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 2114 W. Lafayette Street, Baltimore, MD determined (Specify) Single Family Home 4 Momicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical To the F 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME O.C.M.E. October 24, 2010 146

State

Registrar

Theodore M. King, Jr., MD.

32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

**ORIGINAL** 

111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #27 Per Phy G908 10/28/10 JH State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Octobar 2 er 1132 M Mary Elizabeth Holt Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or, Location of Death **Examiner** 4c. County of Death Prince 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In vrs. last birthday) 8 Date of Rirth **Funeral** 1 M 2X F Months Min (Month, Day, 71 Director 578-52-4654 Usual Residence of Decedent or 28a-f shov 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland Funeral Director Prince George' 1 Yes 2X No MD Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 20706 9320 Fontana Drive USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner I Black, White, et African Be Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: American 3 Widowed 4 Nivorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home maker Domestic 12th Grade NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Winters Harrison Mason Marv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony Holt-Son Cedarhill Road Randallstown, MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Stainislaus 10-25-10 Baltimore, MD Wylie Funeral Home P.A. Street Baltimore,MD 21217 22. Name and Address of Facility 21. Signature of Funeral Service License 638 N. Gilmor CM 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ d disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it any leading to a sequence of the cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner sequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Inneral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by racture 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Concussion 24a Was an autopsy performed 1 ☐ Yes 2 X No 1 ☐ Yes 🙀 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Yes 2 \subseteq No Hospital Other: Certificate: To 12 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural XXX Accident injury 5 Pending work? 1 ☐ Yes 2014No Stairs 0919 M Louin Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 9.3.2.0 determined building, etc. (Specify) ord, No 12 Medical 29a, Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) 10/18/10 00066416 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greenbely 7525 Id MIT am 20770 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2010

DHMH 17 Rev 7/2009

10-08062 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  Selena Magdalene Harris State of Maryland / Department of Health and Mental Hygiene 2010 33834									
	1- For State Certific Registrar	icate of Death	Reg. No.						
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Selena Magdalene	Harris 2. Date of De Month October	Day Year						
	4a. Facility Name (if not institution, give treet and number) 1932 W. North Avenue	4b. City, Town, or Location of Death  Baltimore	NA						
Funeral	Social Security Number 6. Sex 7. Age (In yrs. last)		irth(MM/DD/YYYY) 9. Birthplace (State or Foreign						
Director	225 54 0825 1 M 2 F 7  Usual Residence of Decedent	Yrs. Months Days Hours Min. MAR	1, 1936   Country) V.A						
ow any	10a State 10b County 10c. City, To	wn or Location timore	10d. Inside City Limits  1 Yes 2 No						
1215-0036 Ide filed within 72 hours after death with the Maryland fental Hygiene.  Barked other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at once.  Be Completed by Funeral Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?						
the M Sa or 2 ptified Dire	1923 W. North Ave.	21216	USA						
r death with or items 23 must be no	11. Marital Status 1 Never Married 2 Married Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)</li> </ol>	Io- 14. Race - American Indian, Black, White, etc.						
ter dea	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 No specify:	Specify: Black						
ours aft	10. Booodanto Zasamon (apom) my my	Sa. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry						
5-0036 ed within 72 hour hour hygiener than "natt the Medical Exar Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Domestic	Home						
5-00; ed with tygiene other t	17. Father's Name (First Middle, Last)	18. Mother's Name (First, Middle	, Maiden Surname)						
21215-0036 ald be filed within 7 Mental Hygiene. marked other than c event, the Medica FO BE COMPILE	Ossie Ford	19b. Mailing Address (Street and Numb r or Rural Route N	JATKINS umber, City or Town, State, Zip Code) 4572						
	Richard Ford - brother	4993 South Amatrest 1	Ave. Madison Heights, VA						
e, e, land land Healt litem		ce of Disposition (Name of cemetery, Date matory or other place)	20c. Location - City or Town, State						
Baltimore, permit. Pages I ar Department of Hee Important: If its injury or other tr	4 Donation 5 Other Specify: Me		Catons V. Ile, MD						
Baltimo permit. Page Department c Important: injury or ott	21. Signatur of Funeral Service Leer ee	22 Name and Address Facility Superal S	Home P.H.						
Physician	23a Part. The the disease, or complications that caused the death. De failure List only one cause on each line.	o not enter the mode of dying, such as cardiac or respiratory a	Approximate Interval Between Onset and						
<ul><li>We die al.</li><li>Examiner</li></ul>	Immediate Cause (Final disease a Atherosclerotic Cardiovas	cular Disease	Death						
4	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.								
iner	if any, leading to immediate  Due to (or as a consequence of):  cause. Enter Underlying Couse								
red Framine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
D D is a is is	d.  UNPENDED AMENDED								
'60, ate be physici he buri	IF FEMALE: 23c. If yes, outcome of pregnar		23d. Date of delivery						
Box 68760, c edeath certificate be execution the attending physician and effortuse as the burial - track hysician/Medical	23b. Was decedent pregnant in the past 12 months?  1 Live birth Pregnant at time of death	2 Fetal death 3 Ectopic pregnancy  5 Other (Specify)	Month Day Year						
). Box the death by the atte	1 Yes 2 No 9 V Unknown 9 Unknown		tobacco use contribute to the cause of death?						
P.C s that se detr	•	Anning in the different ying surer great and	res 2 No 3 Probably 4 ✓ Unknown						
Division of Vital Records, rate attending Physician: The law requires rs after death.  al Director: After this certificate has been signed in by the funeral director, page 2 should be refification: To Be Completed			opsy prior to completion of cause of						
Reco		1 ✓ Yes	formed? death? s 2 No 1 Yes 2 No						
tal R cian: 3 certific ector, I	25. Was case referred to medical	26. Place of Death (Check only one)  R/Outpatient 3 DOA Other Nursing Home 5	Residence 6 ✓ Other: Scene						
of Virginia Physics Ferthis eral dir.	1 Yes 2 No 1 Inpatient 2 El	NOdipatient 5 DOA TOTAL TOTAL STEELING TOTAL	he how injury occurred						
on c ending ath. or: Af the fun	1 V Natural 5 Pending 2 Accident Investigation (Month, Day, Year)	1 Yes 2 No							
Division o spital or Attending tours after death. neral Director: After filled in by the fune Certification:	2 Accident Investigation 3 Suicide 6 Could not be	e, farm, street, factory, office building, etc. 28f. Location or Town	n (Street and Number or Rural Route Number, City , State)						
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page ledical Certification: To Be Confedical Certification:		, death occurred at the time, date and place, and due to the ca	ause(s) and manner as stated.						
To the Ho within 24 To the Fu complete!	one) 2 ✓ Medical Examiner: On the basis of examination and and manner stated.	lor investigation, in my opinion, death occurred at the time, da	te and place, and due to the cause(s)						
E S E S	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year) October 21, 2010						
/,	30. Name and address of person who completed cause of death (Item 2)	O.C.M.E.	0000001 21, 2010						
H	Ana Rubio MD. Assistant Medical Examiner 1	11 Penn Street, Baltimore, MD 21201							
State Registra		ared							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #5, per state of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month / Physician/ Doris Belle Ricks Harvin Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Nursing Center N/A Baltimore 5. Social Security Nugate 69 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 8. Date of Birth 1 □ M 2 🔀 F Days Min. Months Hours 0470771934 Maryland 213-32-4469 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director N/A Baltimore Yes 2 No MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2104 Southern Ave. 21214 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Balitimore City (Specify only highest grade completed) Schools Elementary/Seconday (0-12) College (1-4 or 5+) years Educator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental I 2 Solomon Ricks permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Gracie Hamlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2104 Southern Ave., Baltimore, MD 21214 Adger Harvin Jr(Husband) injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 11/05/10 | Baltimore, MD Signature of Funeral Service Licensee <sup>22</sup>Josephidren of Fabrown Jr. FuneraHome PA 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Alzheiner's Immediate Cause (Final Onset and Death End Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Descript at time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month the. Unknown P.O. ed by the signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an certificate has be lirector, page 2 s autopsy performed Yes 2 prior to completion of cause of death? 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 1 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

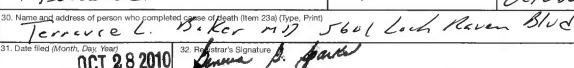
To the Funeral Director: After this or completed filled in by the funeral dii 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

State Registrar

Medical

erravie 31. Date filed (Month, Day, Year)

29b. Signature and title of certifie



Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1137 AM Illick Julia october 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Citizens Nursing Hom DeGrare ge (In yrs. last birthday) Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** If Under 24 Hrs. 8. Date of Birth 1 🗆 M 2 💢 F 08/04/1911 217 46 0161 **Director** Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits Director Maryland Harford Aberdeen 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21001 USA within 72 hours after death with 23 Moyer Dr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S Race - American Indian. Armed Forces?
1 ☐ Yes 2 No Black, White, etc. , or 1 Never Married 2 Married þ 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify White 1 ☐ Yes 2 XNo Specify: Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Egnee. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) At Home Homemaker 12 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emma Rutt Louis Kroening 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23 Moyer Dr, Aberdeen, MD 21001 Edward R. Illick / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) West Chester, 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State 5 Other (Specify) 10/27/2010 Ferris & Co. Pennsylvania 4 Donation Name and Address of Facility arring-Cargo Funeral Home, P.A. 33 S. Parke St, Aberdeen, MD 21001 23a. Part 1. Enter the disea Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence on Cause (Disease or linjury that initiated events the burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No page 2 should be detached for Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 W 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 2 No Yes of Vital Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No ၉ Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division after death. 1 Yes 2 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the only one) t of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of crtifier 31. Date filed *(Mor* State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav Year Month Physician/ Carolyn Johnson—Grant 0 - 23 -7:32 a.m.™ 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** P.G. Southern MD Hospital Clinton If Under If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Year **Funeral** (Month, Day, Year) 0-21-1966 1 □ M 2**X** F Hours Min. Washington DC Months Director 44 578-84-5369 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 X Yes 2 No MD Landover P.G. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 20785 U.S.A. 8104 Finch Ct. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2X No Baltimore, Maryland 21215-0036 1 Yes 2 No SpecifBlack 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other tha any injury or other traumatic ..... Private 10thFood Services Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Dianne Holland James A. Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Wanda Brown/Sister 8104 Finch Ct. Landover, MD 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Riverdale Crematory 11-02-2010 Riverdale,MD 21. Signature of Funeral Service Licensee 22. Name and Address of FaciliRonald Taylor II Funeral Home 108 W. North Ave Baltimore MD 21201 Rand. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Septicemia Physician/ Medical a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence Exami attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Control of the contro Month Day Year Pregnant at time of death 5 i signed by the ai 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? Be Completed by Immuno deticiona 1  $\square$  Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death. Funeral Director: After this certificate has autopsy page 2 performed 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Medical Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. To the F only one) 29d. Date signed (Month, Day, Year) 29b. Signature a October 25 2010 00055120

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

28 2010

1328 Southern avenu SE Suite 31 OWAShington De 20032

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 8:14PM October KAH YON BLYTHER JOHNSON 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore City** The Johns Hopkins Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 1 MM 2 □ F Yrs. 16, 2010 MD Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 No BALTIMORE 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 4912 MIDLINE RD 21206 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 X Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 0 n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BRANDON JOHNSON ADRIENNE BLYTHER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ADRIENNE BLYTHER/MOTHER BALTIMORE, 4912 MIDLINE RD.. MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 \( \overline{\overlin 4 ☐ Donation 5 ☐ Other (Specify) TRINITY 10/27/2010 BALTIMORE, MD 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 21. Signature of Funeral Service Licenses 2007-09 EASTERN AVE., BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sel neonatal disease or condition resulting in death) Due to (or as a consequence f): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day Month Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 10 No 1 🗌 Yes 3 Probably 4 Unknown

**Physician** /Medical Examiner

attending physician

signed by

has

law requires that the death certificate be executed

Box 68760

Division of Vital Records, P.O.

the Hospital or Attending

death.

24 hours

within 2 To the I

Department of Health an Important; If item 27 is any Injury or other trau

Pages 1 ment of H

**Physician** 

/Medical

Examiner

10a State

MD

Director

Funeral

þ

Completed

Be ဂ္

**Funeral** 

**Director** 

?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

nd Mental Hygiene. marked other than

72 hours after

Baltimore, Maryland 21215-0036

IF FEMALE:

Examiner burial-trar Physician/Medical use as the ò Completed Be ၉ funeral Certification: ieral Director: Af

in the past 12 months? 9 Unknown

25. Was case referred to medical

2 No

5 Pending investigation

6 ☐ Could not be

determined

282010

1 🗌 Yes

27. Manner of Death

2 Accident

4 - Homicide

3 Suicide

29a. Certifier (check only

24a. Was an

24b. Were autopsy findings available prior to completion of cause of death? Was an autopsy performed? 2 1 No 1 Yes 26. Place of Death (Check only one)

OA	Otrici.	4 Nursing H	ome	5 Residence	e 6 🗆 Other (
28c.	Injury at Work?		28d.	Describe how i	njury occurred

City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ise(s)

28f. Location (Street and Number or Rural Route Number,

2 Medical Examiner: O		red at the time, date and place, and due to the cau
title of certifier	 29c. License number	29d Date signed (Month Day Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Step name de Wit MD

Hospital:

RES" OCO

October 600 North Wolfe St, Baltimore, MD, 21287

State Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

1 Inpatient

28a. Date of Injury (Month, Day Year)

Barks

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death OCTOBER 25, 2010 Physician/ 11:30 PM JACE JOANN K Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner BALTIMORE GILCHRIST HOSPICE CARE TOWSON Birthplace (State or Foreign Country)
 MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday Funeral Days Hours Months 1 🗆 M 2 🖵 F 12 97 07 7 1 933 MD 216-34-0392 76 Director Usual Residence of Decedent "natural", or items 23a or 28a-f shov dical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County within 72 hours after death with the Maryland Director 1 Yes 2X No PARKTON BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21120 2324 BOND ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces Black, White, etc. à 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: WHITE Completed 3 Widowed 4 X Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry th and Mental Hygiene.

7 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER 12 Be filed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 HENDLER BERNICE permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marked any injury or other traumatic etc. **FLORA** KOLODNY JOSEPH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11623 MANOR ROAD, GLEN ARM, MD KEN FURMAN/SON 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State ARLINGTON CHIZUK AMUNO 10/28/2010 BALTIMORE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. . Signature of Fu 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or comblections that caused shock, or heart failure. List only one cause on each line. ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between nset and Death Immediate Cause (Final Pnysician disease or condition Medical resulting in death) Due to r as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) metasketic physician and s the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last 100 The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year 5 Other (specify) Pregnant at time of death ☐ Pregnam. ☐ Unknown the been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1  $\square$  Yes 2 🗌 No Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 ☐ Yes 2 ☐ No certificate Yes 2 X N To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ပ္ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? Watural 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔁 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [ only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 26 2010 Name and address of person who completed cause of death (Item 23a) (Type, Print)

HMH 17 Rev 7/2009

State Registrar mon

31. Date filed (Month, Day,

Year)

CAMPUEL M

67011

TOWSON MI)

SI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registr<u>ar</u>

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Ruth Amelia Jordan A.M October 11:15 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Golden Living Nursing Home Carrol1 Westminster 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Country)
Maryland 1 □ M 2XXF Months Hours Min 87 Yrs. Director 214-22-1242 D<u>ec</u> Usual Residence of Decedent 3a or 28a-f show t be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 XXVo Carroll Hampstead Maryland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? by Funeral United States "natural", or items 23a dical Examiner must be 21074 3538 Basler Road America 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXNo If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: White 3XXWidowed 4 ☐ Divorced Completed Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 6th Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Henry Weil Emma Cora Rullman traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 2455 Mt. Ventus Road, #2, Manchester, Maryland 21102 Dolores R. Matty (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Oct. 30, Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) New Lutheran Cemetery 2010 Manchester, Maryland Signature of Fungra Some Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 3296 Charmil Drive, Manchester, Maryland 21102 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Impediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ triknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical Hospital Other: 2 🗔 No 1 Yes မ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Aatural 5 Pending injury work?
1 Yes 2 No Accident Investigation the Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined To the Hospital o within 24 hours af To the Funeral Di Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 eelo

State Registrar 31. Date filed (Month, Day, Year)

28 2010

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

15 (TV) CHALUS 21 Stoney Are n

Stoner

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death October Day 23, 2 Ton 0 Physician/ Paula Ann Koenig 5:40A. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Randallstown Baltimore Seasons Hospice Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Maryland Months Hours Month, Day, Yea March21 1 🗆 M 2 🗆 🗶 Director 1944 217-40-0822 66 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho Director 1 Yes 2 No Maryland Baltimore Rosedale 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21237 U.S.A. 6607 Golden Ring Road within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 XDivorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H f item 27 is marked ot r other traumatic ever မ Anna Thelma Murphy Paul Edward Koenig and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christina M. Carroll 12603 Belair Road, Kingsville, Maryland 21087 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or otl 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) ArdentCremation, Inc. 10-27-10 Hanover, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P. A Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as can liac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onsal and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Dav Year signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed Yes 2 2 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Oth 1 🗌 Yes 2 🖾 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural 5  $\square$  Pending 1 Yes 2 No completed filled in by the Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and tifle of certifie limi DUN43375

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October Day 26, 2010 Physician/ 2:59p Laurie M. Knepp Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Baltimore Examiner Towson Gilchrist Center Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, May28 Days Hours 1 M 2 F 51 218-80-2581 1959 Director Usual Residence of Deceden or items 23a or 28a-f show miner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Middle River 1 - Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12 Perch Court 21220 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2x No Specify. White Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Paralegal Law 4yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ James W. Murphy Jane Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy P. Knepp /husband 12 Perch Court Baltimore MD 21220 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place)
Bayview Crematory 10/28/10 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Dicenses 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or com-shock, or heart failure. List only of tations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, he cause on each line. Interval Between Immediate Cause (Final Onset and reath Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence or) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit Physician; The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death 9 Unknow Unknown ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 2 🗆 No Yes 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital ည 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending work? 1 ☐ Yes 2 ☐ No. s after death. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 89b. Signatu of certifie License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 10 Registrar's Signat State 8 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33844 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 10 - 25 - 2010 y Steve L. Kokkinakos 1215 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Harford Bel Air Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 6. Sex 1 M 2 □ F 8 Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours 04-18-1926 Greece Director 216-36-4195 84 Usual Residence of Decedent show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 21 No MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1308 Delphi Ct 21014 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married δ 1 ☐ Yes 2 √ No Specify: Specify: White Completed 3 X Widowed 4 ☐ Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. self employed Restauranter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louis Kokkinakos Eleni Konisotis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1308 Delphi Ct Bel Air, MD 21014 Diane Svrjcek (Daughter) permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other 1 once, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Demetrious Cem. 10-29-2010 Baltimore, MD 21. Signatur Turieral S 1 Com e 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Sever Chronic Chstructive Pulmonary Disease Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown igned by the arbe detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 'ulmonary Hypertensian 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosy Attal funeral director, page Fibri) 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number Medical Doctors 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 upper Checapoake O State 282010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens ( 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death <sup>2</sup>26, 2010 1:20 p<sup>M</sup> October Joseph George Kelly 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4000 North Charles St. Apt.710 Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 XM 2 □ F 161-24-4184 79 12/13/1930 PA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Baltimore MD 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4000 North Charles St. Apt. 710 21218 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 □ ¥ges 2 □ No Army If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 ☐ Never Married 2 Married 1 ☐ Yes 2XNo White Specify Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Realtor Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Joseph Kelly Kathryn McGarvey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorraine T. Kelly / Wife 4000 N. Charles St., Apt. 710, Baltimore, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/28/2010 4 □ Donation 5 □ Other (Specify) Final Journey Crem. Woodbine, MD 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21. Signature of Euneral Service Licensee Dorota Marshall 21203 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CANCER OF THE Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown

The law requires that the death certificate be executed attending physician and for use as the burial-tran Box 68760 P.O. Division or Vital Records, al or Attending P To the Hospitar co... within 24 hours after death.

To the Funeral Director: Aft

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

"natural", or items 23a or 28a-f shovidical Examiner must be notified at

and 2 should be filed within 72 hours after death with itealth and Mental Hygiene.
To 1s marked other than "natural", or items 23a or iner traumatic event, the Medical Examiner must be re-

Department of Health a Important: If item 27 Is any Injury or other trainonce.

**Physician** 

/Medical

**Examiner** 

Baltimore, Maryland 21215-0036

Director

by Funeral

Completed

Be

Examiner

Physician/Medical

Be Completed by

Certification: To

Medical

Part II. Other significant conditions of	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown								
		24a. Was an autopsy performed?  1 Yes X No 24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No								
25. Was case referred to medical	26. Place of Dea	26. Place of Death (Check only one)								
examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing He	Home 5 Residence 6 □Other (Specify)								
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)  28b. Time of Injury  M  28c. Injury at Work?  1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred								
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	nipsician: To the best of my knowledge, death occurred at the time, date and place miner: On the basis of examination and/or investigation, in my opinion, death occu and manner stated.									

HAT

29b. Signature and title of certifier

29c. License number D2533 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TOWER, MARYLAND 21204

State Registrar 31. Date filed (Mont Year) 26 2010 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Month 7:00 A M Physician/ KAMINSK -RMA Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner CARROLL -AIRHAVEN SYKESVILL If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9, Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number (Month, Day, Funeral Country) YORK Months Hours 086 22 5148 82 Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f show 10c. City, Town or Location 10a. State 10b. County Examiner must be notified at Director 1 Yes 2 No SYKESVILLE MK 10g. Citizen of What Country? 10e Street and Number 23a Funeral THIRD AVENUE 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. þ 1 Never Married 2 Married "natural", or 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Completed 3 XWidowed 4 ☐ Divorced injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumers. Elementary/Seconday (0-12) College (1-4 or 5+) MOGRAM Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21+9+9 19a. Informant's Name/Relationship (Type, Print) UL KAMINSK 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🔀 Removal from State 11/1/2010 WOODSTOCK, NY 4 ☐ Donation 5 ☐ Other (Specify) WOODSTOCK CEM 22. Name and Address of Facility AYERS - DURBORAW IEH 21. Signature of Funeral Service Licensee WESTMINSTER MO 21157 Dunberow 91 WILLIS 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final lear Pnysician/ Cel arcinoma disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any adding to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Year Day sate has been signed by the atte page 2 should be detached for Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate 25. Was case referred to medica 26. Place of Death (Check only one) the funeral director, Medical Certificate: To Be examiner? 2 No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work 5  $\square$  Pending Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year)
October 27 2010 29b. Signature and title D34849 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) illiam Janho 31. Date filed (Month, Day, Year) State OCT 28 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day  $\mathbf{A}^{\mathsf{M}}$ Mary Sue Lewis 2010 4:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Carroll Hospice Dove House Westminster 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2XX Hours Min. 10/10/1927 83 Director 215-22-7153 PA Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12036 Gores Mill Rd. 21136 USA death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married þ within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: "natural", 3XXWidowed 4 Divorced Completed White Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) 2 should be filed within and Mental Hygiene 7 is marked other th Rockdale Towing Co. 10 Office Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John E. Knisley Mattie B. Mellott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 short of Health a: If item 27 is 12036 Gores Mill Rd., Reisterstown, MD 21136 Mary Jo Harry/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 🖺 Burial 2 🗌 Cremation 3 🗆 Removal from State 4 Donation 5 D Other (Specify) 10/30/2010 Hillcrest Mem. Park Cumberland, MD 21. Sig e of Funeral Senice License <sup>2</sup>원남판가역선생산한단테<sup>ity</sup>Funeral Home & Crematory, P.A. ranso 1212 W. Old Liberty Rd., Winfield, MD 21784 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, rt 1. Enter the disease, or complications ck, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cancer disease or condition Medical resulting in death) Due to (or as a consuluence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by the a P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available 24a. Was an The law prior to completion of cause of death? Jas page 2: performed? certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatrent 2 **N**No မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral HOSPice To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral Certificate: 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

31. Date filed (Month, Day, Y

29b. Signature and title of certifier

Saion+2, M.D. 555 32. Regis rar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Center St.

29d. Date signed (Month, Day, Year) 10/26/10

Westminster Md, 21117

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** 5:33 PM OCTOBER Deborah Lynn Meyers 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** AGNES BALTIMORE HOSPITAL 8. Date of Birth (Month, Day, June 3, f Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Numbe 7. Age (In vrs. last birthday) **Funeral** Country) Maryland Months Days Hours Min 1 □ M 2 □ F 55 213-68-7310 Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 □Yes 2 □ No r than "natural", or items 23a or 28a-f ships Medical Eranings must be notified Director Lansdowne MD Baltimore 10g. Citizen of What Country? 10e. Street and Number USA 21227 442 Burbank Ct. by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 White If Yes, Give Year or Dates: 1 □ Yes 2 🛣 No Specify Specify: 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Government Sub Contracting Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fil of Health and Mental H f item 27 Is marked oth r other traumatic even Be Nina Fink William Simon ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other traonce. 442 Burbank Ct. Lansdowne MD 21227 Matthew L. Meyers-Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State T Burial 2XXCremation 3 ☐ Removal from State Oct. 27,2010 Glen Burnie MD Atlantic Crematory 4 Donation 5 Dother (Specify) Name and Address of Facility Ambrose Funeral Rome Euroral Service Lin 1328 Sulphur Spring Road Arbutus MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine aftending physician and for use as the burial-trar Due to (or as a consequence of). O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by obstructive Pulmonary disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown poventilation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Mor bid 1 ☐Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 Yes 2 No Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{(Specify)} \) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: Division 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident **Director:** 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO0 70917 OCOBER 25 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVENUE BHAVANDEEP BADAT BALTIMORE, MARYLAND 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

OCT 28 2010

DEBO

MAYERS,

back

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year<sub>20</sub>1 Month October 22, 4:15 AM Physician/ 0 William John Mayer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1955 Midland Rd. Baltimore Dundalk 9. Birthplace (State or Foreign 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8 Date of Birth **Funeral** Days Min. May 31 Year 1941 69 New York 098-32-9378 Director Usual Residence of Decedent or 28a-f show notified at 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 1 ☐ Yes 2 No Baltimore Dundalk 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 5 "natural", or items 23a o Funeral United States 21222 1955 Midland Rd. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 No Maryland 21215-0036 1 Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Real Estate Manager/Instructor Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ပ Mary Flanagan George Mayer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1955 Midland Rd. Dundalk, MD 21222 Veronica Mayer /Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition <sup>ව</sup>්රීස් 25 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland Chesapeake Crematory 2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Funeral Alternatives MO1585 8717 Green Pastures Drive Towson Maryland 21286 Harleman 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death PAN creatic Immediate Cause (Final Ph sician/ OMOSTINS (9~(45 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) nding physician and use as the burial-transit requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical  ${\cal H}$ ්ර Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ ō in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant a Pregnant at time of death the hed t 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Pulmon Obstructue 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has l autopsy performed? death? 1 🗆 Yes 2 🗐 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) or Attending Physician: director, Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 2 No 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Dea 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No thin 24 hours after death.

the Funeral Director: Aformpleted filled in by the fu Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 03840 13/22/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD. Falls Rd HYIT, Comerlle 10753 Sharfman egistrar's Signatu

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year Physician/ PURITA MAGGAY 1503 2010 Medical 4a. Facility Name (if not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** County Months Days Hours Min . 1945 1 M 2 X F Feb 27 611-84-2995 65 **Director** Usual Residence of Decedent r 28a-f show notified at 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 Yes 2 XXO MD Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or Funeral 9300 Canterbury Riding 20723 Philippines items 2 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item ledical Examiner n 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. ò 1 Never Married 2XXMarried 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XXNo Specify: Specify: Asian Completed 3 Divorced Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Meonee. life. DO NOT use retired) within 7 Elementary/Seconday (0-12) College (1-4 or 5+) years School Teacher Elementary Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Antonio Asada, Sr. Josefa Antonio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9300 Canterbury Riding Rodolfo Maggay spouse Laurel, Maryland 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🖾 Xemoval from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) El Camino Mem Pk. 10/30/2010 San Diego, California 21. Signature of Funeral Service Licensee තීර්ක්ඛ්ල්ල්ලිංග් ජීර්තිම්ර්ය Home, P.A. 313 Talbott Avenue Laurel, Maryland ) GCS E / M00770 20707 23a. Part 1. Enter the diselese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MYOCARDIAL BCHEWLA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ITHEROSCHIOTIC CARDIOLASILLOR quertially list ounditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exam burial-transi DIABLACE that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No 4 Pregnant
9 Unknown Month Day Year Pregnant at time of death 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of END STAGE READI DIFFASE ONDIANSIS has autopsy page performed? Yes 2 N death? After this certificate 1 ☐ Yes 2 No ☐ Yes the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Tyes 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending iniury work? Accident 2 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatu d title 29d. Date signed (Month. Dav. Year) OCTOBER 23 2010 11066481 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5755 CHARKENNE MATTHEW J. LELY DO COLUMBIA MD 21044

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

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evan McClary		State of Maryland / Department of I		giene	2010	33851				
		Registrar			g. No.					
Physici		Decedent's Name (First, Middle,Last)	2	<ol><li>Date of Death Month</li></ol>	n Day Year	3. Time of Death				
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ore, slar of Hee If ite		20a. Method of Disposition  20b. Place of Disposition  Crematory or other		Date	20c. Location - City or	Town, State				
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Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum		2 Sonature of Funeral Service Licensee 22. Nar	ne and Address of Facility alvin B. Scrug	ac Fin	neral Hom					
<b>@</b> 80 5.		23a. Part I. Enter the disease, or complications that caused the coat. Do not enter the	112 E Preston	St B	alto Md	21213				
Physician	)3	23a. Part I. Enter the disease, or complications that caused the start. Do not enter the failure. List only one cause on each line.	mode of dying, such as cardiac or r	espiratory arres	st, shock, of heart	Approximate Interval Between Onset and				
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27 Manner of Death 299 Date of Injury 299 Time of Injury 299 Injury at Work? 29d Describe how injury occurred										
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ivision or Attendather death Director:	fica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street,	factory, office building, etc. 26		reet and Number or Run	al Route Number, City				
Dispital of cours at the filled in	Certification:	4 Homicide determined (Specify)	N. Control of the Con	or Town, Sta	ite)					
		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred	l at the time, date and place, and du	ue to the cause	(s) and manner as state	d.				
To the Hos within 24 h To the Fu	To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Check only one 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)									
F # F 5	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, L									
		and	O.C.M.E.		October 25, 2010					
1		30. Name and address of person who completed cause of death (Item 23a)				-				
P	1 11		eet, Baltimore, MD 21201							
Si Regis	ate	31. Date filed (North Day Year) 32. Registyr's Signature								
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Registrar

10-08165 Sue Ann Marcum

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Physician Medical Xaminer    23a. Part I. Enter the disease, or completed on the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	e or  City Limits 2 X No
SUE ANN MARCUM  4a. Facility have fit for institution, give street and number) 6206 Massachusetts Avenue  5. Social Security Number 6206 Massachusetts Avenue  6. Sox 7. Age (in yrs. last birthday) 7. Age (in yrs. last birthday) 8. Social Security Number 6206 Massachusetts Avenue  6. Sox 7. Age (in yrs. last birthday) 8. Social Security Number 6206 Massachusetts Avenue  6. Sox 7. Age (in yrs. last birthday) 8. Social Security Number 6206 Massachusetts Avenue  6. Sox 7. Age (in yrs. last birthday) 8. Social Security Number 6206 Massachusetts Avenue  6. Sox 7. Age (in yrs. last birthday) 8. Months Days Hours Min. 99-38 — 46.33 1 M ZIX F 52 Yrs.  6. Social Security Number 6206 Massachusetts Avenue  7. Age (in yrs. last birthday) 8. BETHESDA  100. State 100. County N	e or City Limits 2 X No
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Director    Og 9-38-4633   1   M 2 X F   52   Yrs.   Months   Days   Hours   Min.   O3/02/1958   Foreign   Country   NT	City Limits
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24a. Was an autopsy findir prior to completion of death?	Jnknown
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27. Manner of Death 28a. Date of Injury FOUND: 28b. Time of Injury FOUND: 28c. Injury at Work? 1 Natural 5 Pending 28d. Describe how injury occurred Subject was assaulted	
Oct 25, 2010 1052 hrs Pending Investigation 2 Accident	mber, City
Subject was assaulted    The control of the control	
Oct 25, 2010 1052 hrs  286. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 4 Homicide 4 Homicide 5 Homicide 6 Could not be determined 6 Copecify) Single Family Home 6 Coefficient on the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  286. Location (Street and Number or Rural Route Nor Town, State) 6 Coefficient on Town, State) 7 Coefficient on Town, State) 7 Coefficient on Town, Stat	
A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Yeiland)	
29d. Date signed (Month, Day, Ye	)
O.C.M.E. October 26, 2010	
30. Name and address of person who completed cause of death (Item 23a)	
Pameta E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State 31. Date filed (Month, Day Year)  Registrar  32. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October Year Physician/ 10: 22 A M LaTasha Moody 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Union Memorial Hospital Baltimore 9. Birthplace (State or Foreign New Jersey If Under 1 Year | If Under 24 Hrs. Social Security Numbe 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Hours 1 □ M 2 🕱 F 0870871973 37 218-84-9603 Director Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State filed within 72 hours after death with the Maryland Director 1X Yes 2 No N/A Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n Funeral U.S.A. 21218 24th Charles Street Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. unk 11. Marital Status "natural", or iter edical Examiner Armed Forces?
1 ☐ Yes 2X No
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha unemployed 12th Grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Myltoria Moody permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Calvin Ingram 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Chesterfield Ave., Baltimore, MD 21213 3520 Elnora Moody (GrandMother) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1x Burial 2 Cremation 3 Removal from State 10/29/10 Zion Cem. Baltimore, MD 4 Donation 5 Other (Specify) Mt. 21. Signature of Funeral Service License 22 Jons 20 Midre Ho. Family own Jr. Funeral Home PA intuch ( Fulton Ave., Baltimore, MD 21217 2140 N. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sepsis we disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or imjury -tran that initiated events resulting in death) Last and Due to (or as a consequence of) burialnding physician ause as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month ō Day Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant : 9 ☐ Unknown , the a signed by the Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? è 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of s certificate has t director, page 2 s autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည this 28a. Date of injury (Month, Day, Year) ithin 24 hours after death.

> the Funeral Director: After the ompleted filled in by the funeral funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 1XX Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one) 29b. Signature and title of certifier T2438946 MD 10/22/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rong Hu Baltimore MD 21218 201 E Univ. UMH Parkway

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

28

State Registrar Charles ST

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regis

ar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔱 📗 🕕 Certificate of Death t's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Day Physician/ Year Month 6:45 PM Octob 2010 Medical Facility Name (if not institution, give stre-Town, or Location of Death **Examiner** 4c. County of Death timore 8. Date of Birth **Funeral** 9. Birthplace (State of onth, pay, Days Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Importment if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Be 17. Father 18. Mother's Name (First, Middle, Maiden Surname) ۵ mcBaltimore, Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2-2010 Signatur of Funeral Service bicenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyin, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) failure pivalory Medical Due to (or s a conservence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a punsequence of): attending physician and I for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be execute that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Ectopic pregnancy Month Day Year ate has been signed by the a page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ᅙ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔭 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has becomine the filled in by the funeral director, page 2: autopsy performe death? 2 🗌 No Yes To Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) AT 2438946 24, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lwen Union Memoral Hospital East 201 32. Registrar Signatur State Registrar

			For State	State of	Marylan		artment of I ctificate of		Mental Hy	0.0	10 22050
			Registrar  1. Decedent's Name (First, Middle	Reg. No.	3. Time of Death						
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	/Medic		Frank Jerom		chazka		4h City Tourn	or Location of Dea	Octobe	er 21, 20	
	Examin	er	4a. Facility Name (If not institution		iber)				ш		
•	and the since		Maryland Mason  5. Social Security Number		7. Age (In yrs.	last hirthday)	Cocke	ysville If Under 24 Hr	s. 8. Date of Bir		imore 9. Birthplace (State or Foreign
4 - 1	Funeral			1 M 2 □ F		Yrs.	Months Days		. (Month, Da	y, Year)	Country)
	Director		219-18-9918 Usual Residence of Decedent		86				Oct 8,	1924	Maryland
	and w		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
	Mary f sho led a	ō	Manual and Dole	d=====		Cool					1 ☐ Yes 2 No
	the 28a-	Director	Maryland Balt  10e. Street and Number	imore		COCK	eysville	:		10g. Citizen of Wh	nat Country?
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	ns 23 mus	Funeral	300 Internati 11. Marital Status	12. Was Dece	dent Ever in U	J.S. 13.1	Was Decedent of	.030 Hispanic Origin? (	Specify Yes or No	- 14. Race	SA - American Indian,
	fter of item	F.	1 ☐ Never Married 2 ☐ Marri	Armed For ed 1 17 Yes If Yes, Giv			t Yes, specify Cut	oan, Mexican, Pue	rto Rican, etc.)	Black,	, White, etc.
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ŏ	2 hou atura cal E	Completed	15. Decedent	's Education		16a. Dece	dent's Usual Occu	pation	- at the -	16b. Kind of Bus	
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2	t that	E	12	02		Dr	aftsman			Governme	nt Contracts
ğ	e filed If Hyg othe /ent,	Be C	17. Father's Name (First, Middle,	Last)				18. Mother's Na	ame (First, Middle	, Maiden Surname	)
a	lid be lenta ked ic e	To B	Josef X.	Pro	chazka			Bessie	<u> </u>	Sasran	ek
Maryland 21215-0036	shot and N		19a. Informant's Name/Relationsh	nip (Type. Print)		19b. Mailir	ng Address (Stree	t and Number or I	Rural Route Numb	er, City or Town, S	State, Zip Code)
Ž	alth a 27 is 27 is		Frank W. Procha	zka/Son		73 1	Windv H	alls Way	. Cockey	sville,	MD 21030
ē,	s 1 a f Hea Item othe		20a. Method of Disposition			Place of Dispo	sition (Name of matory or other pla		Date		City or Town, State
6	°age ento nt: ा∓ or		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 □Removal from S	state		Cemeter		26/10	Poplari 1	lle, Maryland
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		2 September 19 Lyervio		Fa	22	. Name and Addr	ess of Facility			
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				only o e cause on e	a h line.						Interval Between Onset and Death
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	Examiner			Due to (	or as a consec	querice or).					
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687	ficate phy: s the	oi pe		u.							
×	leath certific attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out						23d. Date	of delivery
Vital Records, P.O. Box	eath atter for u	ciar	in the past 12 months?		irth 2□Feta ant at time of		⊒Ectopic pregnand ⊒Other <i>(specify)</i> _	су		Mon	th Day Year
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Sic	tend leath tor: ,	cati	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	at he	_f:=! A+ b	- response of		]Yes 2 □No	005 1 ===6:==	Charles and Alicenter	on on Brown I Bordo Alumba a
<u>≥</u>	or At fter of Direction by	Ħ	4 ☐ Homicide determ	ined 200. Flace buildi	ng, etc. (Spec	sify)	eet, factory, office			wn, State)	er or Rural Route Number,
	To the Hospital or Attending Physician: The law within 24 bours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:		OD- COMITION AND AND AND AND AND AND AND AND AND AN	o Dhusisian: To di-	hoot of residen	owlodge 4	h convered -+ +-	time data and all	no and due to the	onuncial and m	oner as stated
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1			30. Name and address of person					. 2%	1 1	11. 100	21020
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DHMH 17 Rev 1/2001

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			For State	State	of Marylar		artment <i>tificate</i>			lental Hyg	6 U	10	33857
			Registrar  1. Decedent's Name (First, Middle,	Last)		007	incate	OI Dea	107	2. Date of Deat	eg. No.		3. Time of Death
	Physicia Medic		Kendall Holmes Pinion OCTOBEK 16 201									ear 0 0	1201 A M
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and a	Francis		Doctors Commun  5. Social Security Number	ity Hospi	7. Age (In yrs.	last hirthday)	La:	nham Year I If U	Inder 24 Hrs.	8. Date of Birth	1		eorge 'S
	Funeral Director		223-36-0537	1 🛛 M 2 🗆 F	79				ours Min.	Feb. 19	Year) 1931	Coun	
7	o Mo		Usual Residence of Decedent		10.0	-					-		
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ballimore,	permit, rage i and 2 should be lined within 72 hours after dearth with the waryfand Department of Health and Mental Hyghene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lie	ensee	<i>К</i> мо:					aldson E , Laure	Funeral :	Hom∈ 2070	
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ician	certifi	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital:				Tothor:	Death (Check				
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lospital	within 24 hours a 'er dec'th.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier 1 Certifying F	Physician: To the baseminer: On the base	est of my know is of examinatio	rledge, death o	ccured at the	e time, date	and place, and	due to the cause	e(s) and manner a	as stated	d. ise(s) and manner stated.
o the	vithin 2 o the F	Me	only one) 3 Certifying N 29b. Signature and tible of certifier	lurse Practioner:	To the best of m	y knowledge, d	eath occurre	d at the time, icense numb	, date and place	, and due to the c	ause(s) and mann	er as sta	ated.
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	19		30. Name and address & person will A BIODUN,	AZEEZ	8118	6,600		ROA	P, LA	NAMN	us and	070	>6
	Stat Registra		31. Date filed (Month, Day, Year) 0CT 28 2010	General 32. Re	egistrar's Signa	and !							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 33858 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Jose Luis Pina Ruiz October 2010 11:20PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Towson Baltimore Gilchrist Hospice If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. . Social Security Number 614-24-7386 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**火** M 2 □ F (Month, Day, Year) Country) Director 1960 Mexico Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Howard 1 🗌 Yes 2 🔽 No Columbia 10f. Zip Code 10g. Citizen of What Country? Funeral 5764 Stevens Forest Rd Apt 125 21045 Mexico 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify.White 1 Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Landscaping Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည J. Jesus Pina Emerenciana Ruiz injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Dolores Pina (Wife) 5764 Stevens Forest Rd, Columbia MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important; If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State Santa Cruz de Gamboa 11-5-10 Apaseo el Alto 4 ☐ Donation 5 ☐ Other (Specify) Chapel. 22. Name and Address of Facility Marzullo Funeral 6009 Harford Road, Baltimore, 21. Signature of Funeral Service Licensee 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onse and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to firms a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes (2) No 23d. Date of delivery Ectopic pregnancy 3 Pregnant at time of death Month Day Year ed by the a 9 Unknown 9 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed by to completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performer Yes 2 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No 1 🗌 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No М Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature License number 29d. Date signed (Month, Day, Year) 31. Date filed (Month/Day, Year) State 282010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Rhode Physician/ OCTOBER Kuth 6:00 P M 2010 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOWARD 12401 LIMEKILN ROAD **FULTON**  Birthplace (State or Foreign Country) Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number **Funeral** Min. Months Days Hours 06707771913 97 MD Director 215-16-1221 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b. County ms 23a or 28a-f shor must be notified at 10c. City. Town or Location 10a. State Director 1 Yes 2 X No **FULTON** HOWARD MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with al Hygiene.

Jother than "natural", or items 23a USA 20759 12401 LIMEKILN ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, 12. Was Decedent Ever in U.S. an "natural", or iter Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ρ 1 Never Married 2 Married ☐ Yes 2X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: WHITE 3 
▼ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) alth and Mental Hygiene. 27 is marked other thar ir traumatic event, the M LIQUOR STORE CLERK Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည SCHWARTZ MARY DESSER BENJAMIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 13 FAIRWAY DRIVE, REHOBOTH BEACH, DE MYRA KRAMER/DAUGHTER or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of F Important: If ite any injury or ot once, cemetery, crematory or other place, 1 XBurial 2 Cremation 3 Removal from State 10/28/2010 BALTIMORE, MD SHAAREI ZION CONG. 4 Donation 5 Other (Specify) ire of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoc, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ongeshw Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) Cause (Disease or liniury the burial-trans that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Dav Year Pregnant at time of death 1 Yes 2 5 9 Unknown ned by the a detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Records. To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' 1 🗌 Yes 2 🗖 No 2 🖼 Yes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital Other: 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No s after death. 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature and title of certifie

Registrar

DHMH 17 Rev 7/2009

State

1005 Letti Fo myent Bleng Colombia Mo

Internet

# 205

32. R gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cons

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33860 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1 0 Month 20<sup>Year</sup>0 q00:8 22 Harold Delroy Rawlings Sr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 241 N. Monsatery Ave. N/A Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔣 M 2 🗆 F Months Days Hours Min. 1 2 / 3 1 / 1 9 4 6 Maryland Director 63 212-48-1603 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 X Yes 2 No MD N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 241 N. Monastery Ave. 21229 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 XYes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2K No Specify: Specify: 3 Widowed 4 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) vears Artist Self Employed permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James O. Rawlings Viola Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Rawlings(wife) Monastery Ave., Baltimore, MD 21229 241 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Arbutus Cemetery | 10/30/10 | Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee <sup>2</sup>Joseph ddr Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between et and Deal Immediate Cause (Final Myeloid Leer Physician/ disease or condition Medical resulting in death) Due to (or as a consequate of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month 5 Other (specify) Pregnant at time of death cate has been ligned by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No Completed 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law autopsy perform certificate 1 Yes 2 No Yes Division of Vital director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Tes 2 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) 23/2010 and address of person who completed cause of death (Item 23a) (Type, Print) Charles, Street Bouthmore, State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33861 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death October Physician/ 1758 2.010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ARSOR 95 P Eltrore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Funeral 1 - M 2 XX Months Days Hours Min. (Month, Day, Year) une 25 1 MARYLAND Director 66 216-42-2314 June Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director XX Yes 2 No MARYLAND N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 1318 SHELLBANKS RD. 21225 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: If Yes, Give Year or Dates Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 l h and Mental Hygiene. **7 is marked other than** "r Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade HEALTH NURSING ASSITANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. DOROTHY M SHIPLEY ROBERT A SHIPLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shaunetta A. Thomas/Daughter 1318 Shellbanks Rd., Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XX urial 2 Cremation 3 Removal from State MT. ZION CEMETERY 10-28-10 4 ☐ Donation 5 ☐ Other (Specify) LANSDOWNE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE . Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Atheroseleca Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, as a consultience of than y leading to immedia cause. Enter Underlying Cause (Disease or iinjury that initiated events Examin To the Hospital or Attending Physician: The law equires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Fetal deal in the past 12 months? Month Day Year signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Q Q Yes 2 No 3 Probably 4 Unknown Completed r een s 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy pc ge performe death? eral Director: After this certificate filled in by the funeral director, p.g. 2 🗌 No 1 Tyes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 I DOA |은 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature , whoman, m) MySician

DHMH 17 Rev 7/2009

State Registrar

ORIGINAL

South

3001

32. Registrar's Signature

Hanaverstreet balknore 21225

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

			amend #4c Per Phy G908 10728 State of Maryland / Dep	artment of H	lealth and N	n copies A nental Hygi	en@ ()   ()	33862
		•	1 - State Registrar C6	ertificate of E	Death		g. No.	
	Physicia	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	26, 2010 Year	3. Time of Death 3:00 A. M
	/Medic	al	Permelia M. Semmont  4a. Facility Name (If not institution, give street and number)	4h City Town or	Location of Death	October	26, 2010	<u> </u>
	Examin	er	Transitions Health Care	Sykesvil.			Howard Ca	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Birth	place (State or Foreign
	Director		212-10-8315 1 M 2 M F 95 Yrs.	Working Days	110010	Sept. 1:	1,1915 Ma	rýland
	land ow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	.ocation				10d. Inside City Limits
	Mary I-f sh	tor	MD Howard Sykesville	<u>.</u>				1 □Yes 2 📉 No
	or 28:	Director	10e. Street and Number	10f. Zip Code		10	g. Citizen of What Cou	intry?
	s 23a		6966 Hollen Berry Road	2178		positu Vos or No	USA 14. Race - Amer	ican Indian
	item:	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married  13 → Never Married 2 □ Married	. Was Decedent of Hi If Yes, specify Cuba	in, Mexican, Puerto	Rican, etc.)	Black, White,	etc.
036	urs af	by	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 □Yes 2 🔼 No	Specify:		Specify: Whi	
2-0	filed within 72 hours after death with the Maryland Hygene. other than "natural", or items 23a or 28a-f show ent, the Medical Evanither must be notified at	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupa re kind of work done d DO NOT use retired	ation during most of work	sing 1	6b. Kind of Business/li	ndustry
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<u>la</u>	should be filed vand Mental Hygies marked other tumatic event, In	To B	Thomas Pell		Sarah Ha	ıle		
lar)	2 sho and I Is ma rauma	ľ	( ),				City or Town, State, Z	
e, ≥	1 and Health em 27 ther t						Oc. Location - City or T	
nor	ages ant of t: If ite y or o		1⊠ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  Meadowri	position (Name of ematory or other place dge Mem.Pa	ark   10/30	)/2010 E	lkridge, M	D
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evone.		24.00 1. 45 1. 10 1. 10 1. 10 1. 10 1.	22 Name and Address	es of Facility SE	erling As	shton Schwa	5 Witzke
m —	Per Jan Per Series		1 2 Cladena	Funeral Ho 1630 Edmon	idson Ave	nue; Cato	onsville, N	m 21228
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dyin	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
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	/Medical Examiner		Due to (or as a consequence ):	Chan	/			
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Box 68	leath certificate attending phy: I for use es the	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	□ Fatowio wrognone			23d. Date of deli	The second secon
O. B	The law requires that the death certificat ate has been signed by the attending phy agge 2 should be detached for use es th	Physician/Medi	1 Yes 2 No 4 Pregnant at time of death	B ☐ Ectopic pregnancy D Other (specify)	у		Month	Day Year
<b>.</b>	w requires that the d been signed by the should be detached		9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting in the	underlying cause give	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ds,	signe d be c	d by	Alstren Donentia			1	s 2 No 3 Pr	obably 4 Onknown
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		Be C	25. Was case referred to medical examiner?	la:		th (Check only one		150
<u></u>	Physic this c al dire		1   Yes		4 Linursing F	ome 5 Reside	nce 6 Other (Spec	cify)
ou	ding l	tion	1   Autural 5   Pending   (Month, Day, Year)   Injury   2   Accident investigation	/ Work	k? K? Yes 2∐No	20d. Describe no	w injury occurred	
Division of Vital Records,	after death Director: I in by the	Certification: To	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office		28f. Location (Str City or Town	reet and Number or Ru . State)	ral Route Number,
	Ital or rs afte ral Dir led in	Cert						
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely illied in by the funeral director,	Medical	29a. Certifier (Check only one) (Check o	ath occurred at the tir investigation, in my o	me, date and place opinion, death occu	e, and due to the ca arred at the time, da	ause(s) and manner as ate and place, and due	s stated. to the cause(s)
	o the	Mec	29b. Signature and title of certifler	29c. Licens	se number	29	9d. Date signed (Monti	Day, Year)
	->-0			000	30761.		10/17/1	1
			30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)			dn	9 17
			31. Date filed (Month, Day, Year)  32. Registrar's Signature  33. Date filed (Month, Day, Year)	doza	1309	Secon	od Ave. S	Dyresulle, mi
	Sta Registi		QCI 28 2010 Lenga & A	Was				

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# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

33863

			Certificate of Death	Reg. No.						
		Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death					
	Physician	VILLANT CILLINI, 141		OCTOBER 18 2010	60 pm.					
	/Medical	An English Mann (Mant institution aire street and number)	4b. City, Town, or	Locetion of Death 4c. County of Death	h					
	Examiner	Future Care at Cherrywood	Reister	stown Baltin	nore					
		5. Social Security Number 6. Sex 7. Age (In yrs. las								
	Funeral	1DM 2DE	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yeer) 9. Birth Co	hplace (State or Foreign untry)					
Э	Director			Aug 16, 1922 Mar	yland					
	pug 🛊	Usual Residence of Decedent  10a. State 10b. County 10c. City,	Town or Location		10d. Inside City Limits					
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	M	MD Baltimore Cat	tonsville							
	vith the Mar t or 28a-f s be notified	10e. Street and Number	10f. Zip Code	10g. Citizen of What Co	untry?					
	th w	1201 Pleasant Valley Drive	21228	USA						
	fier death v	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert</li> </ol>	pecify Yes or No- to Rican, etc.) 14. Race - Ame Black, White						
0	# # # E		1 ☐ Yes 2 ☒ No Specify:		nite					
8	by Engl	3 ☑ Widowed 4 □ Divorced Year or Dates:	TE 103 ZEENO OPOSIA.	Spearly.						
Q	filed within 72 hours efter death with the Maryland Hygiene.  ther than "natural", or items 23a or 28e-f show ant, the Medical Examiner must be notified at a Completed by Europea Director	15. Decedent's Education	16a. Decedent's Usual Occupation	16b. Kind of Business/	Industry					
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Q	ent, Stage	17. Father's Name (First, Middle, Last)	18. Mother's Nar	me (First, Middle, Maiden Surname)						
<u>a</u>	d be fill antel H cod out	Harry Rock Ambrose	Viola F	laharty						
2	d Ment d Ment marked matic	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Ru	ural Route Number, City or Town, State, 2	Zip Code)					
<u>8</u>	12 s h an r la i	Christie Dembeck Daughter	3 Bonbon Court; Reist							
ص ص	Healt m 2	8	ce of Disposition (Name of	Date 20c. Location - City or	Town, State					
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<u>E</u>	Pa ant: ury	4 □ Donation 5 □ Other (Specify) AT 13		10/22/10 Glen Burn:						
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylen Departmant of Health and Mentel Hygiene. Important: if item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinet must be notified at once.  To Re Completed by Funeral Director	21. Signature of Funeral Service Licensee	22. Name and Address of Facility St Funeral Hone of Ca	erling Ashton Schwa	ab witzke					
œ	8258	MOIOSO MOIOSO	1630 Edmondson Ave	nue: Catonsville, N	MD 21228					
		23a. Part1. Enter the disease, or complications that ceused the death.	Do not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between					
1	Physician	shock, or heart failure. List only one cause on each line.		1	Onset and Death					
Je.	Physician /Medical	Immediate Cause (Final	_	]	6DAYS					
	Examiner	disease or condition resulting in death)		ב ציאני ט						
		Due to (or as a consequence of):								
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	ding physician and se est the bunal-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury	as a consequence of):							
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<u>.</u>	at the	CEREBROVASCULAR DISTASE		1 ☐ Yes 2 ☐ No 3 ☐ P	robably 4 tonknown					
Ś	as this igned be de	CONCISIONASCUME SISTINS	,							
5	quira en si ruld l			performed?	Were autopsy findings available prior to					
္ပ	shoes shoes			· ·	completion of cause of death?					
8	The law raquiry page 2 should Completed			1 Yes 2 0	1□Yes 2E No					
Division of Vital Records,	cartificate irector, pag									
5	Clan:	examiner?  Hospital:	Other	ath (Check only one)	-4.1					
ō	Physician: rthis cartificated and director,	1 Inpatient 2 E	H/Outpatient 3LI DOA 4LE Nursing F	Home 5 ☐ Residence 6 ☐ Other (Spe 28d. Describe how injury occurred	эспу)					
<u></u>	ther the control of t	1 ☑ Natural 5 ☐ Pending (Month, Dey Year)	Injury Work?	250. Busines new injury coounce						
20	Attending or death.  actor: After by the fune	2 Accident investigation 3 Suicide 6 Could not be		28f. Location (Street and Number or R	tural Pauto Number					
$\equiv$	tal or Attanding P rs efter death. al Diractor: After t ed in by the funera	4 Homicide determined 28e. Plece of Injury - At hom building, etc. (Specify)	ne, farm, street, factory, office	City or Town, State)	arai noute ivaliber,					
	rs effer al Dir									
	hou hou hou hou hou hou hou hou hou hou	29a. Certifier  (Check only  Certifying Physician: To the best of my knowl  (Check only  Medical Examiner: On the basis of examination	edge, death occurred at the time, date end place on end/or investigation, in my opinion, death occ	<ul> <li>and due to the ceuse(s) and manner as urred at the time, date and place, and du-</li> </ul>	s stated. e to the cause(s)					
	To the Hospital or Attanding Physician: The is within 24 hours efter death.  To the Funeral Director: After this cardificate ha completaly filled in by the funeral director, page Medical Certification: To Be Com									
	Vithi Vithi Com	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mon						
		In cur	R088852	COTO69120	2010					
		30. Name and address of person who completed cause of death (Item 2	23e) (Type, Print)							
		KADUSSNC. DIAMON & 2835 ST	MITH RUSNUE #203 ON	WIMONS, MANY/AND	21209					
	State	21 Data-filed (Month-Day eVers) 4 22 Pagistrar @Signatu	En Kel							
4.	Registrar	101202010 Century 15. 19								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ AM 2010 0301 Medical 4a. Facility Name (if not institution, give street and number, Examiner City, Town, or Location of Death 4c, County of Death timore 8. Date of Birth (Month, Day, Year) March 17,1932 9. Birthplace (State or Foreign Country) MD In vrs. last birthday If Under 1 Year If Under Funeral Hours 1 □ M 2 😾 213-28-9341 78 Director Yrs March Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturo" any injury or other traumatic even once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 14 Country Mill Court 21228 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 Married 2 X No 1 ☐ Yes 2 X No Specify: White If Yes, Give Specify: Completed 3 Nidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) life DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ridgely B. Taylor Erma Elizabeth Hoefer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Actisdano Daughter 1112 Pleasant Valley Drive; Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Garrison Forest VA Cem 10/28/2010 Owings Mills,MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 Signature of Fune al Service 23a. Part 1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No Day Year Pregnant at time of death 5 Other (specify) Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ. Division of Vital Records, 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performs certificate 2 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at s after death. I Director: After t 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 🗆 No Accident Investigation Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinating and/or investigation is my applied. Chec xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only on Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated **V**ianature on who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day,

8

On

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 – For State Registrar	State of Ma		epartment of F Certificate of I		-	giene Reg. No. 2010	33865
	Physici /Medic		1. Decedent's Name (First, Middle, Last A FEd		1/cus	SR.		2. Date of Dec Month Oc Fusi	Dav Year	3. Time of Death
	Examin		4a. Facility Name (If not institution, give	e street and number)	,	4b. City, Town, or	1 / .	th	4c. County of Dear	th
	Funeral Director		5. Social Security Number 6. S 213-20-7589	ex 7. Age	(In yrs. last birthe	Months Days	If Under 24 Hrs Hours Min	8. Date of Bir (Month, Da Februar	y, Year) Co	thplace (State or Foreign buntry) New York
	/land		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town of	or Location				10d. Inside City Limits
	8a-fsh	Director	Md.		1	Baltimore C	ity			1 X Yes 2 □ No
	with th		10e. Street and Number 3744 Elmora Avenu	10		10f. Zip Code	213		10g. Citizen of What Co	ountry?
	er death	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Decedent of H If Yes, specify Cuba		Specify Yes or No rto Rican, etc.)		
5-0036	be filed within 72 hours after death with the Maryland that Hygiene.  Id other than "natural", or items 23a or 28a-f show event, the Madical Event har must be notified at	by	1 ☐ Never Married 2 😿 Married 3 ☐ Widowed 4 ☐ Divorced	1 ∏Yes 2 □ N If Yes, Give 1 ( Year or Dates)	045·1956	1 □ Yes 2 □ No	Specify:		Specify: W	hite
215-(	hin 72 h e. <b>an "natu</b> Medion	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5-	(9	ecedent's Usual Occup Give kind of work done of ife. DO NOT use retired	luring most of wo	orking	16b. Kind of Business	,
12121	led with lygiene her tha	Com	12th		· I	Pipefitter	40.14.11.11	(First Maidall	Western El	ectric
Maryland	be od o	To Be	17. Father's Name (First, Middle, Last) Alfred G. Sparke					<sub>ime (First, Middle,</sub> n H. Brov	Maiden Surname) I <b>n</b>	
ary	d 2 should be th and Menta 7 is marked traumatic ev		19a. Informant's Name/Relationship (	Type. Print)	l l				er, City or Town, State, .	Zip Code)
	1 and Heal em 2 ther	9	Mary A. Sparkes 20a. Method of Disposition	Spot	,	3744 Elmora		Balto.	Md. 21213  20c. Location - City or	Town State
altimore,	Pages nent of int; If its iry or o		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		1	hisposition (Name of crematory or other place on Forest		30-2010	Owings Mil	
Balti	permit. Page Department ( Important; If any injury or once.		21. Signature of Funeral Service Licen	•	0				Funeral Ho	
			23a. Part 1. Enter the disease, or comp	olications that caused	the death. Do no				Ingham, Md.	Approximate Interval Between
-	Physician		shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	a.	dio Pa	INGNOVY +	Failura	_		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of)	:				luelle
	led sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D	eoneaquanes of)					
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98/80	ficate be physici s the bu	dical		.d						
Rox	ath certi ttending or use as	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	□ Fetal death	3 ☐ Ectopic pregnance	/		23d. Date of de	livery Day Year
Д. О.	the dea by the a	hysici	1 Yes 2 No	4 ☐ Pregnant at 9 ☐ Unknown	time of death	5 ☐ Other (specify) _			World	Day Teal
rds, F	w requires that the death certifice been signed by the attending should be detached for use as	by P	Part II. Other significant conditions of	ontributing to death bu	t not resulting in th	ne underlying cause give	en in Part I.		obacco use contribute t ∕es 2□No 3□P	o the cause of death? robably 4 Unknown
ř	aw as b	Completed						24a. Was autop perfo	prior to death?	utopsy findings available completion of cause of
	Physician: The I this certificate haral director, page	Bec	25. Was case referred to medical examiner?	11 2.1				eath (Check only o	· · · · · · · · · · · · · · · · · · ·	2 2 1140
0	Physi er this c eral dire	2:1	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 ☐ Inpatier 28a. Date of Injur	y 28b. Tin		4 LI Nursing		dence 6 Other (Spe	ecify)
ion	ending sath. or: Afte he fune	ation	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		<i>Year)</i> Inju		? Yes 2□No	-		
DIVISION	al or Att s after de l Direct d in by 1	Certification: To	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc.	ry - At home, farm (Specify)	, street, factory, office		28f. Location (: City or Tox	Street and Number or R vn, State)	ural Route Number,
	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral dir	Medical C	29a. Certifier (Check only one) Certifying Ph	ysician: To the best on niner: On the basis of and manner sta	examination and/	death occurred at the tir or investigation, in my o	ne, date and plac pinion, death occ	ce, and due to the curred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed (Mon:	th, Day, Year)
			12 Name and address	MD	ally (laces on the	1) 00	10767		October	- 61 - 6010
- (			30. Name and address of person who	10 49	ain (Item 23a) (T)	alter A	'e. 1	altino	n MD	11, Day, Year) -2(-2010 2127-4
	Sta Registra		31. Date filed (Month, Day, Year)  OCT 2 8 2010	32. Registra	Bignade					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ METOBER V. Scott LO 10 Carlton Medical 4c. County of Peath 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner PHYSIEIAN: GEOTT, EAALTON PERRY HEALTH EARE MARYLAND If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) NC Days 02-06-45 1 **X** M 2 □ F Months Hours Min. 242-72-8392 65 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at District Director Washington 1 🗆 Yes 2 No DC Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20020 USA 2309 Good Hope Court SE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 

Yes 2 □ No Black, White, etc. Completed by 1XXNever Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Construction Co. Construction worker 11th Grade Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Nola Yates Lonnie Scott KNOWN 19a. Informant's Name/Relationship (Type, Print)  ${ t Brother}$ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherwood M. Scott 2020 Eastbridge Circle Kinston, NC 28501 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State New Bern Mem. 10-31-10 New Bern, NC NAME 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. Street Baltimore,MD 21217 21. Signatule of Funeral Service License 638 N. Gilmor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final EANEER UNG Dualdiand Dual Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner UNKNOWN Sequentially list conditions, ri arry, reading to immediate cause. Enter Underlying Cause (Disease or iinjury NEU MONIA UNKNOWN the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 ☐ Pregnant at time of death g ☐ Unknown 5 Other (specify) signed by the a d be detached f Yes 2 No 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, icate has been siç ; page 2 should b 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗖 No 1 Tyes Yes To the Hospital or Attending Physician; I within 24 hours after death.

To the Funeral Director, After this certifics completed filled in by the funeral director, I Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 A-No 1 🗓 inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending 1 🔲 Yes 2 🗌 No Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type Print)

A V F L I N A L-HERNANDEZ M.D. VA MARYLAND HEALTH CARE SYSTEM 32. Registraris Signature State Registrar

DHMH 17 Rev 7/2009

Division or Vital Records, P.O. Box 68760,

State Registrar DHMH 17 Rev 1/2001

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**ORIGINAL** 

2835

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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27,2010

21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
nend #9 Per FH G908 10/29/10 JH
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician**  $P^{M}$ Dorothy Elaine Smith 10/26/ 2010 3:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 486 Lincoln Drive Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. Date of Birth (Month, Day, Year) 8/14/1926 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖫 F Months 84 Yrs Maryland 219-10-1834 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2526 Wilkens Avenue 21223 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Mactical Examinar 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. þ White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Madden Hilda Nelson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise H. Riley / Daughter 1113 Cedar Cliff Drive, Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Ceme. 10/30/2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Si in tur of Funeral Service Licensee 22, Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant. 3 Ectopic pregnancy Month Year in the past 12 months Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 24a. Was an certificate has autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Lother (Specify) a sust 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner Death 28b. Time of 28d. Describe how injury occurred 1001 Hospital or Attending 24 hours after death. 5 Pending investigation 1 → Matural 1 ☐ Yes 2 No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature odress of person who completed cause of death (Item 23a) (Type/Print)

State Registrar DHMH 17 Rev 1/2001 Dates

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	•	1 - For State Registrar	ate of Marylan		artment of tificate of		nd Mental	Hygier Reg. 1	Z 11	0	33869
Physicia Medic		Decedent's Name (First, Middle, Last)     PAUL HARRISON SCO	ГT				2. Date o	f Death	20, 20	Year OIO	3. Time of Death 3:40 P M
Examir		4a. Facility Name (if not institution, give street at 14920 Plainfield Roa	,		4b. City, Town, German				4c. County o	of Death	У
Funeral Director		5. Social Security Number 220-38-4888  Usual Residence of Decedent	7. Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days		4 Hrs. 8. Date o Min. (Month Aug.	f Birth J. <i>Pay</i> , Year 16 ,	1941	g. Birthp Count M1	lace (State or Foreign Chigan
<b>DEBILLIMOTE)</b> IMBRY/IBING Z1Z13-UU3D permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	10a. State 10b. County MD Prince George 10e. Street and Number 12147 Beltsville Driv 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 XIX ivorced 15. Decedent's Education (Specify only highest grade com Elementary/Seconday (0-12) Col	S Decedent Ever in U.S led Forces?  I Yes 2 XX oss, Give r or Dates.  Detect()  ege (1-4 or 5+)	16a. Decedo (Give k life, DC	10f. Zip Code 20705  Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  □ Yes 2 XXNo Specify:  Dedent's Usual Occupation a kind of work done during most of working DO NOT use retired)  10g. Citizen of What U.S.A.  14. Race - Ar Black, WI Specify:  16b. Kind of Busines National					- America , White, e Whi	an Indian, etc. te ustry pply
Maryland 2 2 should be filed wit tth and Mental Hygie 27 is marked other traumatic event, #	To Be C	17. Father's Name (First, Middle, Last) Paul O. Scott	years	Owne	r / Ope	18. Mother	's Name (First, Mid nice Know	dle, Maide	7.5	ulb,	maintenand
ore, Mal	5 10	20a. Method of Disposition	rs. Rep.	15602 ace of Dispos	Address (Street C Lohr ition (Name of atory or other pla	Road	or Rural Route Nui Thurmon Date	t, Ma		1 2	1788
Saltimore, bernit. Page 1 and Department of Hea mportant: If item any injury or othe		1 ☐ Burial 2 XX remation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	Wes	t Arun	del Cre	n. 1	0/22/2010 al Home,		denton	, Ma	ryland
Medical Examiner bhysician and the burial-transit the burial-transit	dical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events  c.	that caused the death on each line.  Letastatic ue to (or as a consequence to	Rectal ence of): er		ng, such as ca	ardiac or respirator	y arrest,			Approximate Interval Between Onset and Death 4 years 8 years
ne death certifica r the attending ph	/We	in the past 12 months?	s, outcome of pregnan Live Birth 2  Fetal Pregnant at time of de Unknown	death 3	Ectopic pregnan Other (specify)	су			23d. Date Mont		ry Day Year
The law requires that the law requires that the law requires that the last been signed by page 2 should be detailed.	þ	Part II. Other significant conditions contributin	g to death but not resu	lting in the un	derlying cause g	ven in Part I.	1	☐ Yes	2 <b>XX</b> No 3	Prob	e cause of death?
ian: The law artificate has b	Be Completed	25. Was case referred to medical examiner?			26. F	lace of Death	24a. W a p 1 🗆 Y (Check only one)	vas an utopsy erformed?	pri	ere autope or to com ath?	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certificate: To	1  Yes 2 XXo Hospital:  27. Manner of Death  1  Aratural 5  Pending  2  Accident Investigation  3  Suicide 6 Could not be  4  Homicide determined	1 ☐ Inpatient 2 ☐ E Date of Injury (Month, Day, Year)  Place of Injury - At hombuilding, etc. (Specify)	8b. Time of injury	28c. Inju wor M 1 L	4 ⊔ Nurs vat	28d. Descrit	oe how inju	ury occurred		Residence Route Number,
To the Hospital within 24 hours. To the Funeral I completed filled	Medical	29a. Certifier (Check 2 Medical Examiner: On to only one) 3 Certifying Nurse Practic	ne basis of examination a	and/or investic	ation, in my opini	on, death occu e time, date a	irred at the time, da	te and place the cause	e and due to	the caus er as stat	se(s) and manner stated. ed.
5		30. Magne and address of person who completed	cause of death (Item 2	Sa) (Type, Pri	0	315	51		100		21,2010
Stat Registra	e		32. Registrar's Signatur	re land	יטון כיי	> ((1) T	( ( V ) )	1 1 1	0/62	W W	100 - Tulua

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Ma		epartment of He Certificate of D		ental Hygie	ZUIU	33870
	Physici /Medio		Decedent's Name (First, Middle, Last	Dean I	Brian	Shaw		2. Date of Death Month October	<sup>Day</sup> 26, 201	3. Time of Death 8:01a M
	Examir Funeral Director		4a. Facility Name (If not institution, give  Genesis Nurs  5. Social Security Number  307-32-2064	ing & Re	(In yrs. last birth	4b. City, Town, or I  La P  Iday) If Under 1 Year  Months Days		8. Date of Birth (Month, Day, Ye 1 2 / 1 7 / 1	Charle 9. Birth Co	h
	Maryland -f show	tor	Usual Residence of Decedent  10a. State	es	10c. City, Town	or Location White	e Plains			10d. Inside City Limits 1⊠Yes 2 □ No
	h with the 13a or 28a	al Director	10e. Street and Number 4210 Southwin	ds Drive	#116	10f. Zip Code 20	0695	10g.	Citizen of What Co	buntry?
9036	swihin 72 hours after death with the Maryland jiene. r then "neturel", or tteme 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 【※**IDivorced	12. Was Decedent E Armed Forces? 1 XYes 2 N If Yes, Give 10 Year or Dates:	Navv	13. Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 ☑ No	spanic Origin? (Spe n, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
Maryland 21215-0036	i within 72 jene. r then "na the Medic	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 1 2	cation e <i>completed)</i> College (1-4or 5- 4	(	Decedent's Usual Occupat Give kind of work done du life. DO NOT use retired) Graphic A	uring most of workin	ng	Eximal of Business/Publish	,
/land	d be file ental Hy ced oth c event	To Be C	17. Father's Name (First, Middle, Last) Elvin Shaw	,				(First, Middle, Mai te Ordu		
	and 2 shoul selth and Me n 27 is mark ser traumetl		19a. Informant's Name/Relationship (Ty Lorraine D. Ir	pe, Print) ons/Daug	hter 3		nd Number or Rura Catown R	Route Number, C. Load, Wa	ty or Town, State, 2 ldorf, l	MD 20601
Baltimore,	Z H	35	20a. Method of Disposition  1 Burial 2 XCremation 3 F  4 Donation 5 Other (Specify)		Final	Disposition (Name of crematory or other place) Journey Crem	n. 10/28	/2010 V	Location - City or loodbine,	MD
Balt	permit. Pag Department Importent: any Injury o		21. Signature of Funeral Service does	Dorota M	4.4	22. Name and Address Maryl PO BO	and Creix 1413,	mation : Baltimo	Services ore, MD	21203
£8260, €	hysician and physician and physician and physician and physician and is the burial-transit	ai Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or as a	consequence of	):  Conce with				Approximate Interval Between Onset and Death
P.O. Box 68		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at the 9 □ Unknown	Fetal death	3 Ectopic pregnancy 5 Other (specify)			23d. Date of deli	ivery Day Year
	quires that an signed by ruld be deta	Ď	Part II. Other significant conditions cor	otributing to death bu	t not resulting in t	he underlyi <i>n</i> g cause given	n in Part I.	23e. Did tobac	1 / 1	the cause of death?
Division of Vital Records,	: The law re cate has be ; page 2 sho	Completed						24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of
of Vit	hystciar this certif al directo	To Be	1 163 2 2 10		t 2 ER/Outp	atient 3 DOA Other	Nursing Hom		6 □Other (Spec	cify)
sion (	Attending Physician: r death. ector: After this certifics by the funeral director, p	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day	Year) Inji	ury Work? M 1 ☐ Ye	at 2 es 2 No	8d. Describe how i	njury occurred	
<u>&gt;</u>	5 를 등 드		4 Homicide determined	building, etc.	(Specify)	n, street, factory, office		City or Town, S.	,	
	o the Hospitel ithin 24 hours of the Funeral I ompletely filled	ledicai	29a. Certifier 1 Certifying Physical Check only one) 1 Certifying Physical Examination (Check only one)	ician: To the best of ter: On the basis of and manner stat	examination and	death occurred at the time or investigation, in my opin	n, date and place, a nion, death occurre	nd due to the cause d at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the comple	Σ	29b. Signature and title of certifier  Lishberg hus	A.		29c. License i	70900	29d.	Date signed (Month	n, Day, Year)
_	1+1		30. Name and address of person who co		ath (Item 23a) (T		1m, zilog	21401		
	Sta Registra		31. Date filed (Month, Day, Year)  OCT 28 201(	32. Aegistra	's Signature	barre	- r			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 26 Physician/ October Mary I. Sands 2010 9:17a м Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Co. Gilchrist Car<u>e Cente</u>r Towson Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9-26-1916 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Min. Hours 212-09-6873 94 Yrs **Director** Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits N/A MD Baltimore City 1 X Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21224 808 S. Streeper Street USA 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: "natural", Completed 3 X Widowed 4 Divorced Specify: White event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+)  $\stackrel{\wedge}{N}$ Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frank Trocki Alice Widonska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Sands- Son 1425 Kingscrest Rd. Midlothian, VA 23114 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Redeemer Cem. 10-29-2010 Baltimore, 22. Name and Address of Facility Kaczorowski Funeral Home, PA Dundalk Avenue Baltimore, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) Due to (or a la consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 Inpatient 2 DOA 4 Nursing Home 5 Residence 6 Nother (Spec 27. Manner of Death 28a. Date of injury (Month, Day, Year) 1 Natural Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending Accident
Suicide 1 🗌 Yes 2 🗌 No 24 hours after death Funeral Director; completed filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, (Check

State Registrar

only one 29b. Signature

31. Date filed (Month, Day, Year)

28

no title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signat

within 2

6701

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

29d. Date signed (Month, Day, Year) October 26 2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 05 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** owsor On rimor If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. Funeral 1 M 2 X Davs Hours Min (Month, Day, Director Usual Residence of Decedent or 28a-f show 10a State 10b County 10d. Inside City Limits 10c. City. Town or Location Examiner must be notified at Director IA 1 Yes 2 □ No 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? 23a Funeral "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by within 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: 3 ₩idowed 4 □ Divorced injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental 0 70 19a. Informant's Name/Relationship (Type, Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is .Shrop amela Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 2-2010 4 Donation 5 Other (Specify) 21. Signifure of Funeral Service Licensee any 23a. Part I Enter the lisease, or complications that caused the death. Do not enter the mode of ding, such as cardiac or respiratory arrest, shock, or heart fillure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ obstructive pulmonary diseace chronic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) and -transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day Veal Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown s been signed by the should be detached Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has e 2 autopsy page perform death? this certificate 2 No 1 🗌 Yes 2 No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Hospital Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After work? 1 Yes 2 No injury Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 0070635

Registrar

DHMH 17 Rev 7/2009

State

Baltimore

Suite 4605

N churles St

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

670

Pat

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ¿Physician/ Month T SHTGLET + LLI AN MARGURITE 10:25PM Medical 2010 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOWAR D GENTRAL HUSPITM DHUMB(A HOWARD COUNTY 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth 1 □ M 2 🗓 F Days Min. Hours Director 216-50-9488 203-1949 Country Germany Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Howard Laurel 1 Yes 21 No 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 9932 Hughes Avenue 20723 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2X No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Manager Food Service Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Russell Conover Lucienne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1880 Clark Station Road Severn, Maryland 21144 Suezann Linton Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory | 10-22-2010 | Odenton, Maryland 21. Signature of Euneral Service Licenses 22. Nonadison Fulheral & Crematory, PA M01176 1411 Annapolis Road Odenton, Maryland 21113 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death SEPTIC 5 Hour disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner HYDRONEPHROSINS CHRONIC KIDNEY DISE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events DIABETES MELLI TUS attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of). Physician/Medical RIGHT ADRE MAZ IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No signed by the atte Month Pregnant at time of death Unknown Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ TR ACK Completed 1 Yes 2 No 3 Probably 4 Unknown plnous been Were autopsy findings available prior to completion of cause of death? MILTI ORGAN FAILU 24a. Was an has page 2 autopsy performed? Yes 2 No 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မှ 1 Yes 1√∑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 2 🗌 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 24 hours after death. e Funeral Director: After this certificate completed filled in by the within 2

4

DHMH 17 Rev 7/2009

State

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MBONY

only one 29b. Signature and title of certifle

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2 U Medical Examiner: On the basis of examination and/or intresugation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

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29d. Date signed (Month, Day, Year)

21

RD, COLUMBIA MA 21044

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 2010 DOROTHY STERN 314 10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BAUTIMORE FUTURE CARE CHARLES VILLAGE NIA If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month, Day, | Dac 3 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 15 F Director Ala bama Usual Residence of Decedent shov 10a. State 10h. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Mary land 1' Yes 2 No Baltimore ms 23a or ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United Sta Lakewood 21213 items 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Medical Examiner Armed Forces<sup>1</sup> Black, White, etc. 5 Completed by 1 Never Married 2 Married 1 Yes 2 Ho filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black "natural" 3 DWidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education Kind of Business Industry (Specify only highest grade completed) a Himore of Health and Mental Hygiene. item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the 2 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Page 1 and 2 should be ames 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) harlotte -Daushter Glencreck 6/K-tan, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of Important: If it any injury or o cemetery, crematory or other place) unt Cav Mel Ca 1 Burial 2 Cremation 3 Removal from State Oct. 29 2010 Baltimore, 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign up of Funeral Service Licensee abrin 2-12 Ba 1-to-, MO hilton 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on Interval Between Immediate Cause (Final disease or condition Onset and Death System/ Medical resulting in death) Due to (or as a consequence of): Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami transit and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical ore Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Live Birth 2 Live Canal Pregnant at time of death in the past 12 months?

1 Yes 2 Ho Month the detached g Unknown P.O. ģ been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Slavar 8 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 UNO မှ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Dewatural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D31464 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SHOA[|3] A. HOSHMI \$2(N. EKTAW) ST Finte 308 Balt. MD 21201

V DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

OCT 28 2010

32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	1 - For State of Maryland / Department of Health and Mental Hy  Certificate of Death	/giene Reg. No.	10 3	33875
	Physici				2010	3. Time of Death 7, 17 A M
	/Medic Examin		Ab City Town or Location of Doub	4c. C	ounty of Death	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Bi Months Days Hours Min. 6. Sex 1. Age (In yrs. last birthday) Months Days Hours Min. 5-24-	irth lay, Year) 1921	9. Birthp Cour	place (State or Foreign otry) VA
	Maryland 9-f show	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  MD Anne Arundel Odenton			0d. Inside City Limits 1 ☐ Yes 2X No
	with the a or 28c	Direc	10e. Street and Number 10f. Zip Code 21113	_	n of What Coul JSA	ntry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depurtment of Heatth and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23a or 28e-f show any injury or other treumatic svent, it a New Call Examinal mission multilised at 2006.	by Funeral Director		lo- 14	. Race - Ameni Black, White,	
215-00	ithin 72 hou ne. nan "nature	Completed		16b. Kind	of Business/In	
Baltimore, Maryland 21215-0036	ld be filed w ental Hygier ked other th ic svent, ILS	To Be Cor	17. Father's Name (First, Middle, Last)			
, Mary	and 2 shoul salth and M 27 is mari er treumati	F	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number of Rural Route Numbe	n, Ma	ryland	21113
imore	Pages 1 and of He ent: If item ury or oth		20a. Method of Disposition  1		nsville	, Maryland
Balt	permit. Departi Importi any nji		21. Signature of Funeral Service Ucensee M01176 M01176 LALI Annapolis Koad Odento	on, Ma		
	Physician /Medical		23a, Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock in heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a	arrest,		Approximate Interval Between Onset and Death
	Examiner	ıer	Sequentially list conditions, if any, laading to introducte cause. Enter Underlying Cause (Disease or injury  Due to (or as a consequence of):			
760, Chi	be executed sician and burial-transit	Ical Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
O. Box 687	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medic		23	d. Date of deliv Month	ery Day Year
Ω.	quires that i n signed by uld be deta	by	Part II. Other significant continuous continuous to death but not resulting in the unusurying cause given in ract.	tobacco use		he cause of death? pably 4 Hunknown
I Reco		Completed	24a. Wa auto per 1   Yes	formed?	24b. Were auto prior to co death? 1 \( \sum \text{Yes}	opsy findings available impletion of cause of 212 No
Division of Vital Records,	To the Hospitel or Attending Physicien: Th within 24 hours after death.  To the Funerel Director: After this certificate completely filled in by the funeral director, pag	To Be	25. Was case referred to medical examiner?  1	sidence 6	ther (Speci	my Howe
Division	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	2 Accident investigation 3 Suicide 4 Homicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location City or To	(Street and lown, State)	Number or Rur	al Route Number,
	he Hospitu n 24 hours ne Funere stetly fille	ledical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the composition of the basis of examination and/or investigation, in my opinion, death occurred at the time and manner stated.	e, date and p	lace, and due t	o the cause(s)
	To tl withii To tl comp	Me	29b. Signature and title of certifier & Wilh # M.D. 29c. License number D4 1865	29d. Date	signed (Month,	Jay, Year)
_	140		30. Name and address of person who completed eause of death (Item 23a) (Type, Print) 3900 Loch Roven F George E. Wicks H. Battimove)	Man	read	21218
	Sta Registr		OUL & U ZUIU ZA ALA . BE ABA AL I			

After t within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):				
	d. X UNPENDED	AMENDED 23a,27,28a-f per	me g912 2-4-1	ll vt		
-	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal de 4 Pregnant at time of death 5 Other (	eath 3 Ectopic pregna	ancy	23d. Date of delivery Month Da	y <b>Y</b> ear
	Part II. Other significant conditions	contributing to death but not resulting in the under	lying cause given in Part I.		pacco use contribute to th	e cause of death? bly 4  Unknown
				24a. Was an autops perform	y prior to conned? death?	psy findings available mpletion of cause of 2 No
	25. Was case referred to medical		26.Place of Death (Check	only one)		
	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3	DOA Other Nursin	g Home 5 🔲 F	Residence 6 🗸 Other: S	Scene
ı	27. Manner of Death	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe ho	ow injury occurred	
	1 Natural 5 Pending 2 Accident Investigat	fd 10.21 10 fd 1120b	1 Yes 2 X No	unknow	1	
	3 Suicide 6 X Could not determine		ctory, office building, etc.	28f. Location (St or Town, Sta <b>Luke</b> ,	reet and Number or Rura ate) 239 Fair Md. 21540	
		cian: To the best of my knowledge, death occurred a r:On the basis of examination and/or investigation, in and manner stated.				
	29b. Signature and title of certifier	/	29c. License number		29d. Date signed (Monti	n, Day, Year)
	enne -	to MP	O.C.M.E.		October 22, 2010	

111 Penn Street, Baltimore, MD 21201

OCINE

33876

3. Time of Death

1130 hrs

10d. Inside City Limits

1 Yes 2 X No

Approximate Interval

Between Onset and

Death

9. Birthplace (State or

Country) WV

DHMH 17 Rev 1/2001 OCME 2006

State Registrar 30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

Russell Alexander MD.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month OCTOBER <u> 2010</u> 11:15 AM ROBERT LEE WYATT, Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE GILCHRIST HOSPICE CENTER TOWSON 8. Date of Birth
(Month, Day, Year)
JAN. 15, 1945 Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours 1 🔀 M 2 🗆 F Director 215-40-4122 65 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 ☐ No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2006 E. LANVALE ST 21213 USA 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 BLACK 1 Yes 2 X No Specify: 1 and 2 should be filed within 72 hours aft of Health and Mental Hygiene. item 27 is marked other than "natural", other traumatic event, the Medical Exal 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12TH LABORER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ ROBERT WYATT, SR MARY NEWBILL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 ELAINE WYATT/WIFE BALTIMORE, MD 2006 E. LANVALE ST. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of I
Important: If ite 1 X Burial 2 Cremation 3 Removal from State injury 4 Donation 5 Other (Specify) 10/23/2010 BALTIMORE, MD TRINITY 21. Signature of Funeral Service Licenses 22. Name and Address of Facility WESLEY CHAVIS, JR. P.NRL. 2007-09 EASTERN AVE. , BALTIMORE, 21231 23a. Part 1. Enter the disease or complications that caused the ceath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) en Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed for use as the bunal-transi that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death been signed by the should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy After this certificate funeral director, pag 2 🗆 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 - Nursing Home 5 - Residence 6 Other (Specify) NOSpul 2 No မ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Matural 5 Pending To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completed filled in by the fur Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 📂 Certifying Physīcian: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar only one)

ANU N 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHAMES

29b. Signature

DHMH 17 Rev 7/2009

W

\$2. Registrar's Signature

701

29d. Date signed (Month, Day, Year)
ONDIGAL (8 20 10

N. Charles St Tonson MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Year Month Wheeler Harry AM 0400 2010 Medical Eacility Name (if not institution, give street and number) 4b City, Town, or Location of Death **Examiner** 4c. County of Death If Under 24 Hrs. 8. Date of Birth Funeral If Under Year Birthplace (State or Foreign Country) 1 **X** M 2 □ F Days Director 213-30-3091 Usual Residence of Decedent 28a-f show 10a. State with the Maryland the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Ferndale 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21061 1010 Big Baer Drive U.S.A. and 2 should be filed within 72 hours after death wealth and Mental Hygiene. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. "natural", or þ 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Automotive Repair Auto Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Elizabeth Voyce Evelyn Wheeler David 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 11170 Chambers Court Woodstock, MD Mr. Earl Harry Wheeler, Jr./Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Page 1 g 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Balto. Nat'l Cemetery 10/29/2010 Baltimore, MD 22. Name and Address of Facility 1 2nd Avenue SW Signature of Funeral Service Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) · Dil Licile Medical Due to (or as a consequence of) Examiner 00(1 YEar Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Divisito for es a consectience of: burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): physician at the burial-Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 XUnknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🖾 No Certificate: To Other: 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P25719 12010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 North Greene Street Ba Ltimbe MD 26201 Hantha

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

28 2010

32. Registraf's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33879 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2 Physician/ Jessie Wingate October 1:35  $A^{M}$ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Baltimore NA Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 □ M 2 □ F Days Hours 216-20-8152 **Director** Usual Residence of Decedent or 28a-f show 10c. City, Town or Location filed within 72 hours after death with the Maryland or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD NA Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 3906 W. Coldspring Lane 21215 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. African 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: American Completed 3 XWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event, the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Social Security Elementary/Seconday (0-12) College (1-4 or 5+) Claims Department 12th Grade Administration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Bennett Flora Mayo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda P. Holmes-Daughter 3906 W. Coldspring Lane Baltimore, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place)
Druidridge Cem. 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11-01-10 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License Wylie Funeral Home P.A. 22. Name and Address of Facility 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one dause on each line. Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition Medical resulting in death) Due to (or s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Dav Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe 2 No 1 Tes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 မှ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death

1 Natural
2 Accident
3 Suicide
4 Homicide Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Putel

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31. Date filed (Month, Day, Year)

6701

N Charles

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Donald A. Wiles Physician/ October 26, Day 2010 P. M. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death N/A 2913 Miles Avenue Baltimore Social Security Number Birthplace (State or Foreign Country)
 MD . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 XXM 2 □ F Months Days Hours Min. Dec 16, 192 **Director** 212-22-1506 84 Usual Residence of Decedent 28a-f show 10a. State with the Maryland must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MDN/A 1XX Yes 2 🗌 No Baltimore 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral U.S.A. 2913 Miles Avenue 21211 Page 1 and 2 should be filed within 72 hours after death a ment of Health and Mental Hygiene.
ant, if item 27 is marked other than "natural", or items uny or other traumatic event, the Medical Examiner m. uny or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give XX 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 3 Widowed 4 Divorced Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXNo Specify. Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Contracting Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lester M. Wiles Ruth Penner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2913 Miles Avenue Balto, MD 21211 Alice Wiles (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of I
Important: If ite
any injury or ot
once. 1XXBurial 2 Cremation 3 Removal from State Lorraine Park Cemetery 10/29/10 Balto, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lic 22. Name and Address of Facility
Burgee Henss-Seitz Funeral Home, 3631 Falls Road Balto, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or impury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar resulting in death) Last Due to (or as a consequence of). Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death 2 No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 XNo 1 🗌 Yes 3 Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 Tes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital Other: ပ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pending 24 hours after death. Funeral Director: A 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 29a. Certifier Qertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 ho

To the Fune

completed fi Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar
/DHMH 17 Rev 7/2009

State

30 Fa

1 Rd

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Sigr

State of Maryland / Department of Health and Mental Hygiene [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ October 5:15 PM WILLIAM DAVIDSON WIGHT Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Laurel Regional Prince Hospital George's Laure 5. Social Security Number 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**√X**M 2 □ F Months Davs Hours Min. Aug 123, Year 925 Country) Illinois Director 352-16-9008 85 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 Yes 2 KNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3144 Gracefield Road, Apt. 421 20904 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Armed Forces?

1XXYes 2 \( \text{No} \) No \( 1943 \) Black, White, etc. Š 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2XXNo Specify: Specify: 3 ₺ Widowed 4 □ Divorced Completed White Year or Dates -196915. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retirestaff Personnel 2 should be filed within 72 h th and Mental Hygiene. 7 is marked other than "n (Specify only highest grade completed) United States Elementary/Seconday (0-12) College (1-4 or 5+) LT. COL. / Officer Air Force 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David C. Wight Janet Davidson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Suzanna Wight Kelley / daughter 1603 Sherwood Road Silver Spring, Maryland 20902 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XXurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat. Cemetery 1/27/11 Arlington, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 45 M00770 207070 23a. Part 1, Enter the disea or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 18 Hours shock, or heart failure. List only one cause on each line Immediate Cause (Final Failure ₽nysician/ Respirator disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ongestive Heart Days Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury 5chemic \_drd10m1 attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 s, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 1 ☐ Yes 2 L 9 ☐ Unknown the ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Sepsis 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy performe death? this certificate 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 X No ᅆ 1 X Inpatient 2 - ER/Outpatient 3 - DOA eral Director: After th filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Tes 2 🗌 No hours after death. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) hin 24 hours a the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ene October 22, 2010 D0017502 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14201 Park Drive Laurel Rene L. Gelber, MD aure! 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

ORIGINAL

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State of Maryland / Department of Health and Me  Certificate of Death		eg. No 10	33882
ľ	Physicia /Medic		T	. Date of Deatl Month October	Day Year 22, 2010	3. Time of Death 7:21AM
-	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Cambridge		4c. County of Dear	
-	Funeral Director		216-54-9584 126M 2 F 60 Yrs. Months Days Hours Min.	Date of Birth (Month, Day, arch 29	9. Bird (Co.) 1950	hplace (State or Foreign untry) MD
	Maryland a-f show filed at	ctor	Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or Location   Cambridge   C	140		10d. Inside City Limits 1  Yes 2 □ No
	h with the 23a or 28a st be not	al Director	701 Race Street Apt. 426 10f. Zip Code 21613	10	0g. Citizen of What Co	ountry?
900	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	d by Funeral	11. Marital Status  1 Never Married 2 Married  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 No If Yes, specify Cuban, Mexican, Puerto Rick Year or Dates: 10 Army Year or Dates: 10 Army Year or Dates: 10 Yes, Specify Cuban, Mexican, Puerto Rick If Yes, Specify Cuban, P	y Yes or No- can, etc.)	14. Race - Ame Black, Whit Specify:	
215-0	d within 72 ho giene. r than "natu the Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)		16b. Kind of Business	Industry
d 21	filed wi Hygien ther th		12 Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (F		I / A Maiden Surname)	
ylan	2 should be a nand Mental is marked o raumatic eve	To Be	3	Cole		
, Mar	s 1 and 2 should be filed I Health and Mental Hyg Item 27 Is marked othe other traumatic event,		19a. Informant's Name/Relationship (Type. Print) Laura Jones / Niece   19b. Mailing Address (Street and Number or Rural F 809 Maces Lane, Ca)			
Baltimore, Maryland 21215-0036	6 - E		20a. Method of Disposition  1	/2010	20c. Location - City or Woodbine,	MD
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee Dorota Marshall  22. Name and Address of Facility Mary Land Crema PO Box 1413,	tien altim	Services	21203
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):		est,	Approximate Interval Between onset and Death
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.O. Box	the death certily the aftending ached for use a	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome pf pregnancy  1 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)		23d. Date of de Month	livery Day Year
rds, P	iw requires that the s been signed by the should be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	oacco use contribute to es 2 □ No 3	o the cause of death?
or Vital Record	The law ate has b page 2 sh	Completed		24a. Was ar autops perform 1∐ Yes 2	v nrint to	utopsy findings available completion of cause of 2 \square No
Vita	Physician; Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1   Yes		ence 6 <b>S</b> Other <i>(Spe</i>	Niece's
o uc	ding Phy h. After thi funeral (	ion: T	27. Magner of Death 1 Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28c. Injury at Work?		w injury occurred	
Division	or Atten ifter deat Director in by the	Certification:	an existing 6 Could not be	f. Location (St City or Town	reet and Number or R n, State)	ural Route Number,
	he Hospital n 24 hours a he Funeral I pletely filled	Medical C	29a. Certifier (Check only one)  12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and compared to the death occurred and manner stated.	d due to the ca at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To the I within 2. To the I complet	ž	29b. Signature and title of certifier  OUNDE AIRE MO P57639		9d. Date signed (Mon.	
	371		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Koven Moffet Mo 83D Chesapeate Dr.  31. Date filed (Mapth, Day, Year)  32. Registrar's Signature	Can	bidge	NO
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month. CHOOLR 0034 2010 Medical 4a. Facility Name (if not institution, give street and number 4c.;County of Death **Examiner** 4b. City, Town, or Location of Death mouryland Greneral Amure 8. Date of Birth 5. Social Security Number (In yes. last birthday) g. Birthplace (State or Foreign Age **Funeral** 218-48-1029 1 M 2 G F Months Hours Min. Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral West Franklin USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? 1 Yes 2 No Black, White, etc. Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black If Yes, Give Specify: 3 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) aintenanc Be Father's Name (First, Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) ည lacabee Garnes ouna rainia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto MD 21229 Lowler Cousin lilde 012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Catonsville, mo 4 Donation 5 Other (Specify) Funeral Gervine Lic 21. Signature o Pass er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate
Interval Between
Onset and Death shock, of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Immunodeficiency Ph\_sician/ DWRLD Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence or): To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Yes 2 No g Unknown Part IJ. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: The Is within 24 hours after death.

To the Funeral Director: After this certificate h Dustipidemia, Emphysema 2 XNO 1 Yes as case referred to medical examiner?

1 X Yes 2 No Be 26. Place of Death (Check only one) Hospital ပ 1 Inpatient 2 XER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 1 Natural 28d. Describe how injury occurred 5 Pending Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (nel)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

28 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State of I	Marylan		artment <i>tificate</i>			and M	lental Hy	giene Reg. N	201	0	33884
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	Medic Examir		4a. Facility Name (if not Friends Ho			•							c. County of	Death	У	
	Funeral Director		5. Social Security Numb	18	Sex 7.	Age (In yrs. Ia	as <i>t birthd</i> ay) Yrs.	If Under 1 Months		If Under 2 Hours	24 Hrs. Min.	8. Date of Bir OCCONTH, Da	th Year)	922	9. Birthp Coun	place (State or Foreign try) PA
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	n with the h is 23a or 2 nust be no	Funeral Di	10e. Street and Number 17340 Quak		e			10f. Zip 0		-1297				itizen of Wh	at Cour	itry?
920	72 hours after death with the Manyland "natural", or items 23a or 28a-f sho hedical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 3🏋Widowed 4 ☐		12. Was Deceder Armed Forces 1 Yes 2 If Yes, Give Year or Dates	S? X No	lf	Vas Deceder Yes, specify	Cuban,	Mexican,		cify Yes or No- Rican, etc.)		14. Race - Black, Specify:	White,	
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. In important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	(Specify Elementary/Seconda				Ìife. DO	ind of work ONOT use n	done dur etired)	ion ring most	of workin	g		Kind of Busi	ness Ind	dustry
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	and 2 should I Health and Me tem 27 is marl other traumati		19a. Informant's Name/ Kathryn Zi	/Relationship (7	Type, Print)	ter	1	g Address (S H <b>o</b> gar	Street and	d Number	r or Rural	Route Numbe				Code) ia 22151
=	permit. Page 1 ar Department of He Important: If iter any injury or oth once.		20a. Method of Disposit  1 Ki Burial 2 □ C  4 □ Donation 5 □	Cremation 3X	X Removal from Sta	te Co	lace of Disposemetery, crem Led Met	atory or oth	er place)	em.		<sup>ate</sup> 0/2010		ocation - C on To	-	wn, State nip, PA
Bai	Depar Depar Impor any in	2.	21. Signature of Eugera	to	_ /	M0077	/0 [3]	13 Tal	bott	Ave	nue	ome, P Laure	1, M	Maryla	nd	20707
-4	hysician Medical	50	23a. Part 1. Enter the d shock, or heart fai Immediate Cause (Fina disease or condition resulting in death)	ilure. List only o	ne cause on each l	ine.	art Dis		or aying, :	such as c	ardiac or	respiratory an	rest,		14	Approximate Interval Between Onset and Death Years
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P.O. Box 6876	to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hard redath.  Within 24 hard after death.  Within 24 hard birector. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	/Me	IF FEMALE: 23b. Was decedent pregin the past 12 monto 1 ☐ Yes 2XXNo 9 ☐ Unknown	ths?	23c. If yes, outcom 1  Live Birtl 4  Pregnan 9  Unknown	n 2 🗌 Fetal tat time of d	I death 3	Ectopic pre Other (spec						23d. Date (		ery Day Year
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Division of Vital Records,	n; The law re- icate has be r, page 2 shc	Comple	OF West and the second											pric	or to cor	nsy findings available inpletion of cause of 2 No
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on of	l or Attending Physician: The law after death. Director: After this certificate has I in by the funeral director, page 2 (	Certificate: T	2 Accident	Pending	28a. Date of in (Month, E	jury	28b. Time of injury		. Injury at work?	t s 2 🗆 i	28	8d. Describe h	ow injur	y occurred	<i>ъреспу)</i>	
Divisi	ortal or Att		4  Homicide	Could not be determined	28e. Place of II building, e	etc. (Specify)						City or Tow	n, State	)		Route Number,
:	o the Hosp vithin 24 ho o the Fune completed f	Medical	(Check 2 🔲 I	Medical Exam Certifying Nun	sician: To the best of iner: On the basis of the Praction of T. II	examination	and/or investi-	gation, in my	opinion.	death occ	:urred at t	he time, date a	nd place	<ul> <li>and due to</li> </ul>	the cau	ise(s) and manner stated
	h		30. Name and address	person who	completed cause of	death (Item	23a) (Tvpe. Pr	D	259					ober		•
	Q		Evelyn Jac	kson, N	4.D. 554	0 Ten	Oaks F	,	Clar	ksvi	lle,	Maryla	and	2102	9	
	Stat Registra		31. Date filed (Month, Da		32. Regis	trar's Signatu	ure									

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33885 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 15 Joan M Anthon 10 Medical 4a. Facility Name (if not institution, give street and number, County of Death Examiner 4b. City, Town, or Location of Death Anne Arundel Glenburnic, MD 111 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🛛 F Months .1<u>931</u> 194-28-6372 79 Director Yrs Pennsylvania Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Arnold 1 ☐ Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21012 USA 570 Bellerive Road Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 X Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Health Care Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Alice Condron Manus Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
112 Sunset Drive Glen Burnie, MD Theresa Ellenberger/ Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory, INC. 20a. Method of Disposition 20c. Location - City or Town, State October 12 2010 1 Burial 2 X Cremation 3 Removal from State ö Baltimore, MD any injury o 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Ballanco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause or imjury Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Tes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform eral Director; After this certificate filled in by the funeral director, pag 2 🗆 No Yes 2 🗓 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No ٩ 1 Tes Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 [ ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) AAde 10/10/2010 MD DO069727.

Registrar
DHMH 17 Rev 7/2009

State

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back

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ademiposi Adlybuly Pro BWMIC 30

32. Registrar's Signature

31. Date filed (Month, Day, Year)

301 Hospital Drive, Elen Burnie MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month 1840 M 2010 Physician/ October Melvin P. Asquith Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Anne Arundel Riva 3132 Riva Road If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Country) Months 71 1 X M 2 - F 1938 November **Director** 213-36-0729 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10a. State 10b. County the Medical Examiner must be notified at Director 1 Yes 2 No Riva Anne Arundel Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō Funeral 23a 21140 31<u>32 Riva Road</u> 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) items 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 11. Marital Status Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medic 1 Examir once. ģ 1 Never Married 2 Married 1 Yes 2 No Specify: White Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Parking Garage Attendant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Doris Richardson Peter P. Aisquith, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 300 9th Ave., Glen Burnie, Maryland 21061 Deborah G. Snyder 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State 10-12-2010 | Edgewater, Maryland All Hallows Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final rteriosclerotic Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to lor as a consequence of attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Day Year in the past 12 months?
1 Yes 2 No Pregnant at time of death signed by the a g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 □ Unknown 1 Yes 2 No this certificate has been si ral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 26. Place of Death (Check only one) 25. Was case referred to medical Be funeral director, exammer? Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 2 No ျ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Certificate: After injury 5 Pending Natural 1 ☐ Yes 2 ☐ No M Accident
Suicide Investigation within 24 hours after death

To the Funeral Director: A 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) 21035 State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 33887 State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3. 2010 October 8 Physician/ Irene Sabine Anderson 7:57 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Months Hours Min. 04/15/193 Germany Director 514-40-5562 79 Usual Residence of Decedent 28a-f show 10b. County death with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Anne Arundel Edgewater 10e. Street and Number þ 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 3911 West Shore Drive 21037 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. "natural", or þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 🕅 Widowed 4 □ Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important; If item 27 is marked other than any injury or other traumativ. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Antiques Dealer Antiques Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Otto Magnus Hermine Koss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark A. Anderson/ Son 227 Biltmore Pl., Panama City Beach, FL 32413 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 10/13/10 Edgewater, MD A Physial ervit Licensee 21. Signaty 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each liny. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a c Examiner Sequentiary liet conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death Year 1 La res 2.5 9 Dunknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) exammer? Hospital ၉ 2 🗌 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident Suicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 1) certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 20 6 30. Name and address of person who completed cause of cleath (Item 23a) (Type, Print) Judy H. JosephHerbert, M.D. 31. Date filed (Month, Day Ye. 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Lorraine Avis 2:57 AM Florence 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Hospice At the Salisburg Lake Wicomico ('oastal 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. 1 🗆 M 2 🗶 F 83 Months Hours 218-20-8659 **Director** 03/30/1927 New Jersev Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director Hebron 1X Yes 2 No Maryland Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21830 USA 104 Grove Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 No Specify: white Specify: 3 Widowed 4 Divorced Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit, Page 1 and 2 should be filed within 7. Dep. rtment of Health and Mental Hygiene. Imp. rtant. If item 27 is marked other than any inury or other traumatic event, the Me Elementary/Seconday (0-12) Baha'i World Center administration Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ပ Edna Zeluff Rober Morris Ayers 19a. Informant's Name/Relationship (Type, Print)
Randa Wilbur/daughter 19b. Mailing Address (Street and Number or Rural Route Number City or Town State, Zip Code) 1545 Portia Rd., Grayslake, IL 60030 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 10/9/2010 Jerusalem Cemetery Parsonsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) Service Licensee Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 arra portugal CFSP 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ BRBAST CARCINOMA MALIGNANT disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated as control of the Examine Due to (or as a consequence of) the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) signed by the attending physician a be detached for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 5 Other (specify) Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has blirector, page 2 s autopsy performed? Yes 2 No 1 Yes 2 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? Hospital: 4 Nursing Home 5 Residence of Other (Specify) HOSPICE ၉ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) 29b. Signature a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B0 0 80 6 Huym 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 to 2010 Registrar

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Floor

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene

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Physici	an/	Decedent's Name (First, Middle,Last)					2. Date of De	ath			3. Time of Death
edical Exami		Derryl Eric Brandenburg					Month October	Day 13, 20	)10 Year		0915 hrs
		4a. Facility Name (if not institution, give street and number)		4b. City, T	Town, or	Location of D			c. County o	f Death	
		11 West Baltimore Street		Hage	rstown			_   '	Washing	ton	
Funeral		Social Security Number	ist birthday)	If Unde	er 1 Year	If Under 24	Hrs. 8. Date of B	irth(MN	1/DD/YYYY)	9. Birtl	hplace (State or
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			Yr	rs.			Oct.	18,	1954	000	
<u>*</u>		Usual Residence of Decedent  10a. State 10b. County 10c. City,	Town or Loca	ation		_					10d. Inside City Limits
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faryl 28a-1	ect	10e. Street and Number		10f, Zip	Code			10g. Ci	tizen of Wh	at Coun	try?
the N	Director	11 West Baltimore St.		2	1740	)		U	.S.A.		
with 23;	Га	11. Marital Status 12. Was Decedent Ever in U.					( Specify Yes or N			Americ	can Indian, Black,
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ter de	Щ	1 Yes 24 No 3 Widowed 4 Divorced If Yes, Give Year	1	Yes 2	X No	specify:			Specify:	Whi	te
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36 in 7,	ple	2	Auto/	Aircr	aft	Mechar	nic	Ι,	uto D	210	ership
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12 Id be fenta arke	o Be	19a, Informant's Name/Relationship (Type, Print )	19h Mailir	na Address	(Street	Mary C	Saylor Br	and o	enburg	State	Zin Code)
MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. In 77 is marked other than 1 matic event, the Medica	ĭ										
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S a s a graffe			rematory or o			letery,	Date	200.	Location -	City Oi	TOWIT, State
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiew in Properties of Health and Mental Hygiew in Propertant: If time 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other Specify:	se Hill	L Ceme	eter	y 10	0-18-2010	) H	lagers	tow	n, MD
alti. Dartm ports		21. Signature of Funeral Service Licensee	22.	Name and	Address	of Facility D	ouglas A.	Fi	erv F	unei	ral Home
		Knittin Bollanon S. tis	13	331 Ea	astei	rn Blv	d. North	Hag	ersto	wn.	MD 21742
Physician		23a. Part I. Enter the disease, or complications that caused the death.	Do not enter	the mode o	of dying,	such as cardi	ac or respiratory ar	rest, sh	ock, or hea	rt	Approximate Interval
/Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Gastrointestinal Hemorr	thage com	nlicating	Athar	necleratio	Cardiovascula	r Disa	220		Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of		phoating	/ terici	0001010110	<del>Curaiova</del>	1 0100			
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	i.	cause. Enter Underlying Cause (Disease or injury that initiated									
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Box 687 he death certifi	sician	1 Yes 2 No 9 Unknown 9 Unknown	atn 5 C	Other (Spec	cify)						
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n ding	on	1 Natural 5 Pending (Month, Day, Year)			1□ Y	es 2 No					
Sior Attend or death ector: by the	cat	2 Accident Investigation 28e. Place of Injury - At ho	ma form atr	not factory			28f Location	Stroot	and Numbe	or Pur	al Route Number, City
Division pital or Attendir ours after death.	ertification:	Suicide 6 Could not be	me, iami, sue	eet, ractory,	, onice bi	aliding, etc.	or Town,		and Numbe	O I Kui	a Noute Number, City
Spita spita nours neral	Ö	4 Homicide									
e Ho n 24 l e Fu letely		29a. Certifier 1 Certifying Physician: To the best of my knowledg									
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	one) 2 Medical Examiner: On the basis of examination are and manner stated.	aroi irivestiga				ou at the thile, trate				
	Σ	29b. Signature and title of certifier		290	. License						th, Day, Year)
		Carol Hallan			O.C.N	Л.E.		Oc	tober 14,	2010	
		30. Name and address of person who completed cause of death (Item	23a)								-
H-10		Carol Allan, MD Assistant Medical Examiner	111 Penn	Street, E	Baltimo	ore, MD 21	201				
S	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signatur	re _								
Renis		OCT 1.8 2000 / /	- A	-4							

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	_	foAmend Item 5 State of Maryland / D State of Maryland / D State of Maryland / D Registra WCHD/SH 10/22/10 per FH	epartment of Health and N Certificate of Death		ene2010 33891
Physicia		1. Decedent's Name (First, Middle, Last)  Jerry Gayle BURT		2. Date of Death Month	Day Year / 4h 2010 / 07 PM
Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	acluber	4c. County of Death
Funeral Director		905 Queen Anne's Court  5. Social Security Number  464-64-1236  1 □ M 2 ☒ F  71 Y	Months Days Hours Min	8. Date of Birth (Month, Day, Yo	Washington  9. Birthplace (State or Foreign Country)  1938 Texas
faryland Ba-f show tified at	ector	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town of	or Location agerstown	<u></u>	10d. Inside City Limits 1 ☐ Yes 2▼ No
h with the N ns 23a or 2	Funeral Director	10e. Street and Number  905 Queen Anne's Court	10f. Zip Code 21740	10	g. Citizen of What Country?
i, or	ρ	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates.	<ul> <li>13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto</li> <li>1 ☐ Yes 2 ▼ No Specify:</li> </ul>	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
thin 72 hour sne. than "natu ne Medical	Completed	(Specify only highest grade completed) (( Elementary/Seconday (0-12) College (1-4 or 5+)	Decedent's Usual Occupation Give kind of work done during most of work fe. DO NOT use retired)	ing 16	6b. Kind of Business Industry
be filed wit lental Hygie rked other ic event, th	as l	12 0 3  17. Father's Name (First, Middle, Last)  Woody Gerald Willis	Homemaker  18. Mother's Nam  Mary Eliz	e (First, Middle, Mai zabeth Bra	•
id 2 should salth and M n 27 is mai er traumat		19a. Informant's Name/Relationship (Type, Print)	Mailing Address (Street and Number or Rur D7 Links View Drive	al Route Number, C	ity or Town, State, Zip Code)
Page 1 an ment of He tant: If iten to othe jury or other		20a. Method of Disposition 1 ☐ Burial 2 【▼ Cremation 3 ☐ Removal from State  20b. Place of C  cemetery,		Date 20	oc.Location - City or Town, State agerstown, Maryland
Departit Depart Import any inj		21. Signature of Funeral Service Licensee	22. Name and Address of Facility 415 E. Wilson Blvd		Funeral Home town, Md. 21740
Physician/ Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	Curco	or respiratory arrest.	Approximate Interval Between Onset and Death
Examiner	ner	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of)			
e be executed /sician and e burial-transit	cal Examiner	cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last  C. Due to (or as a consequence of)	:		
tificate ring physies as the t	Medic	d			
Io the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9  Unknown  23c. If yes, outcome of pregnancy 1  Live Birth 2 Fetal death 4  Pregnant at time of death 9  Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phycompleted filled in by the funeral director, page 2 should be detached for use as the		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		cco use contribute to the cause of death?  2 No 3 Probably 4 Unknown
The law recate has be page 2 sho	Completed by			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No
nysician: nis certifi director,	To Be	25. Was case referred to medical examiner?  1	26. Place of Death (Chec latient 3 DOA Other: 4 Nursing Ho		ce 6 ☐ Other (Specify)
ttending Fi death. tor: After th the funeral	Certificate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	work?  M 1  Yes 2 No	28d. Describe how	
ortal or A ours after eral Direc		4 Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)		City or Town, S	,
o the Hosi ithin 24 ho the Fune	Medical	29a. Certifler (Check 2 ☐ Medical Examiner: On the best of my knowledge, de only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowled 29b. Signature and title of certifier	nvestigation, in my opinion, death occurred a	t the time, date and pose, and due to the ca	place, and due to the cause(s) and manner stated.
= ≥ <b>≓</b> ŏ		30. Name and address of person who completed cause of death (Item 23a) (Ty	10 04/667	290	10/15/10
H-3		Michael McCormack /1110		come	Househun Mo
State		31. Date filed (Month, Day, Year)  32. Registrar's Signature		1 - 7	10

DHMH 17 Rev 7/2009

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 16:2ZM Ctober 2010 Sr. Charles Brown /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Hagerstown Washington County Hospital If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** 6. Sex 1 M 2 □ F Director 219-14-8913 85 6/14/1925 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County i and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show railmatic event, the Micdical Exeminer must be notified it. 1 Yes 2 No Director Maryland | Washington Boonsboro 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 141 S. Main St. 21713 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clinical Engineer Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be flik Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event once. Be Lillian Mae Burns Francis Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21102 San Mar rd. Boonsboro Maryland 21713 William Brown / Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Rest Haven Cemetery 10/19/2010 Hagerstown Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 1DAY disease or condition resulting in death) 1251 /Medical Due to (or as a consequence of): **Examiner** PNEVNONIA FEW DAYS Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transit UBSTRUCTIVE PULMO MARY DISENSE Chrowic. and be execu Due to (or as a consequence of): physician s the burial Box 68760. Physician/Medical certificate attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No o. cate has been signed by the page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ SELFRE TIL CARNID VASEVLAR 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ d Jaknown Completed DISEASE FIBRILLATION HYDRETENSIO V24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? DISEASE CHRONIC KIDWRY DISEASE certificate PARKINSONIS 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Hopatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Alatoral spital or Attendi nours after death. neral Director: A / filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifier 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier at MO 218019 OCTUBER 15 2013 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAKERSTOWN MD SH-5 57 340 MILL VASANT DATTA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33893 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month $\underline{201}\overset{\mathsf{Year}}{0}$ Physician/ October 7:44 P M Woon Cha Brooks Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav) Funeral 1 □ M 2 🗶 F Days Hours Min Korea Director 266-02-6433 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County must be notified at Director 1 🗆 Yes 2 🗓 No Anne Arundel Marvland Edgewater 10f. Zip Code 5 10e. Street and Number 10g. Citizen of What Country? items 23a 21037 USA 1321 Sundee Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Examiner Armed Forces? 1 Yes 2 X No Black, White, etc. ٥, þ 1 Never Married 2 Married 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: "natural", 3 X Widowed 4 □ Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than, filed within al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Home 12th Homemaker other event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H f item 27 is marked ot r other traumatic even permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ၉ unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1321 Sundee Drive, Edgewater, MD 21037 Veronica Webber/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State 10/12/10 Kalas Crematory Edgewater, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Exami physician and s the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Year 5 Other (specify) Day Pregnant at time of death signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ြု this After thi funeral 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide

Box 68760 P.0. Records, Division of Vital Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: A completed filled in by the fu To the I

Maryland 21215-0036

Baltimore,

29a. Certifier Certifying Physician: To the best of my knowledge, death occ		
(Check 2 Medical Examiner: On the basis of examination and/or investigation		
only on 3 Certifying Nurse Practioner: To the best of my knowledge, dea	ath occurred at the time, date and place, and di	de to the cause(s) and manner as stated.
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
who of the Month.	D16376	10/11/2010
1 94798 4 0 1 5 WEST	210210	10/17/010
30. Name and appress of person who completed cause of death (Item 23a) (Type, Pring	W _ ^	
LOCAL MARCAN DAY NAME !	Dh (1)	1: MA DILLAR
Local Moser in 2001 Medical	Hoy Angto	Us / (1) X 1901
31. Date filed (Monti May Year) 3 2010 32. Fegistrar's Signature	011	
001 13 2010	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	

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City or Town, State)

State Registrar

Medical

determined

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33894 For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Browand William October 01:10 A M 2010 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, **Baltimore City** The Johns Hopkins Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Sep 23, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 193-38-5927 62 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 Yes 2 No Belgrade Gallatin Montana 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number USA 59714 5690 Foster Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 N Yes 2 □ No If Yes, Give Vietnam Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2X No Specify white Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Commercial College (1-4 or 5+) Elementary/Secondary (0-12) Real Estate Sales Associate 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Eleanor Jaymes Robert O. Browand 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5690 Foster Lane, Belgrade, MT 59714 Diane Browand, wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/17/2010 Rolling Green Cem. Camp Hill, PA 21. Sign ture of Funeral Service Licenses 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between

**Physician** /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit

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s after death. I Director: After t filled in by the

within 24 hours a To the Funeral Completely filled To the

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**Physician** 

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Examiner

Director

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**Funeral** 

**Director** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Examiner Medical Certification: To Be Completed by Physician/Medical

Immediate Cause (Final disease or condition		renal o	ell carcin	oma	Onset and Death	
resulting in death)	Due to (or as a consec			21.104		
Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or as a consec	quence of):				
that initiated events resulting in death) Last	Due to (or as a consec	quence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn  1  Live birth 2 Fet  4  Pregnant at time of c	al death 3 🗌 Ectopi	c pregnancy specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions co	ontributing to death but not re	sulting in the underlyii	ng cause given in Part I.	23e. Did tob	acco use contribute to the cause of death? s 2 ☑No 3 ☐ Probably 4 ☐ Unknown	
				24a. Was an autopsy perform	prior to completion of cause of	
25. Was case referred to medical			26. Place of De	ath (Check only one	)	
examiner? 1   Yes 2   No   Hospital: 1   Inpatient 2		□ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Re		Home 5 🗌 Resider	sidence 6 - Other (Specify)	
27. Manner of Death  1 Natural  2 Accident  5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1  Yes 2  No	28d. Describe ho	w injury occurred	
3 Suicide 6 Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
					ause(s) and manner as stated. ate and place, and due to the cause(s)	
29b. Signature and title of certifier	anature and title of certifier 2		29c. License number		29d. Date signed (Month, Day, Year)	

RES OCO

October

600 North Wolfe St, Baltimore, MD, 21287

9,2010

DHMH 17 Rev 1/2001

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gensher mer

32. Registrar's Signature

ichae

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Beverly Ann Beatty DM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Westminster Carroll Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral Age (In yrs. last birthday) Days 1 □ M 2 K F Months Hours Min. (Month Day, Year) 5V 15, 1939 Mary land 212-38-1182 70 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Maryland Carroll Westminster 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21157 521 Sullivan Road USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white Specify: 3 🗌 Widowed 4 🗎 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cafeteria Worker Food 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Walter Wimert Hilda Petry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 521 Sullivan Road, Westminster, MD 21157 Harold F. Beatty, husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Westminster Cemetery | 10/11/2010 Westminster, MD 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service License 91 Willis Street, Westminster, MD 21157 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ANOXIC ENCEPHALGP.A Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** VENCRICULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying DULMONARY HYPERTENSION Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page performe 1 Yes 2 No I ☐ Yes 2 🖊 No Be 25. Was case referred to medical 26. Place of Death (Check only one) funeral director Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No 1 → mpatient 2 □ ER/Outpatient 3 □ DOA 1X Yes မ After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident injury work' 5 Pending after death. 1 Yes 2 No Investigation the 3 Suicide within 24 hours after de
To the Funeral Directo
completed filled in by th 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier D30263 WIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCIS KHOO, MD ZOO MEMORIAL AVE, WESTMUSTER, MD 21157 4 31. Date filed (Month, Day, Year) 32. Reg etrar's Signature State backer

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ĭŎ, 20ÏÖ 2:00 A. M Fleeks Burleson October 0 Lela /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Washington Adventist HOspital Takoma Park If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Year) Days 1 □ M 2 🕱 F 87 461-20-5784 July 13,1923 Crockett, TExas Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, Its Modical Examination modified at 1XYes 2 □ No Director District of Columbia Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20018 United States 4011 - 21st Street, N. E. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Black Maryland 21215-0036 1 □Yes 2 No Specify. Ω. 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) U.S.Department of Navy Data Processor 4 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eddie **Patterson** Fleeks Solomon. ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1131 Chalk Hill Lane; Charlotte, North Carolina 28214 Gloria F. Dempsey (Daughter) permit. Pages 1 and Department of Health Important: If Item 27 any injury or other to once. Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Oct.19,2010 1 Burial 2 □ Cremation 3 □ Removal from State Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 22. Name and Address of Facility R. N. Horton Company Morticians, Signature of Funeral Septic Cens Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed and Due to (or as a consequence of) burialattending physician for use as the buria Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 \subseteq Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.0. the 9 XUnknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate DCh(1 □Yes of Vital Physician: 25. Was ase referred examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 **N**O 1 Inpatient 2 ER/Outpatient 3 DOA ၉ this funeral 27. Mann Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred After t Division Hospital or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of cer 30. Name and address of person who completed c use of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of Mary		artment of F tificate of D			ne 2010	33897	
	Dhysisia		Decedent's Name (First, Middle, Las					2. Date of Death		3. Time of Death	
and the same	Physicia Medic	al	Beatrice 4a. Facility Name (if not institution, give		Center	41 Oits Town	Location of Death	October	17, 2010	2:10 AM	
and.	Examin	er	Fox Chase Rehabil				r Spring		Montgo		
	Funeral		5. Social Security Number 6. So	7. Age (ln)	rs. last birthday) 06 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yo	9. Birt	hplace (State or Foreign intry) rth Carolina	
	Director		578-18-8274	1904 No	rth Carolina						
	/land f shov ed at	g t loa. State 10b. County 10c. City, Town or Location									
	e Mary r 28a- notifie	10a. State 10b. County 10c. City, Town or Location  Washington  10e. Street and Number 10f. Zip Code 10g. Citizen of What 10g. Citizen									
	with th 23a o Ist be	eral	732 Adrian St	reet SE			0019	10	United	-	
980	e filed within 72 hours after death with the Maryland trai Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Wildowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 🔼 No		ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Af 1		
Maryland 21215-0036	in 72 hou e. nan "natu : Medical	Completed by	15. Decedent's E (Specify only highest gra Elementary/Seconday (0-12)		(Give	dent's Usual Occup kind of work done o O NOT use retired)	ation Juring most of work	ing	6b. Kind of Business	ndustry	
121	d with tygien ther th	Be C	6th  17. Father's Name (First, Middle, Last)			Domesti		e (First, Middle, Ma	Priva	ite	
lanc	be file lental H rked o ic eve	일		am Jones				Mariah Ba			
lary	1 and 2 should be filed within 7 f Health and Mental Hygiene. item 27 is marked other than other traumatic event, the M		19a. Informant's Name/Relationship (T						ity or Town, State, Zip		
	and Healt		Margaret B. Webst 20a. Method of Disposition		r 6/20 b. Place of Dispo	Newbold		ethesda,	Mary Land Oc. Location - City or	20817	
mor	<b>e = </b>		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific	Removal from State	cemetery, crer	natory or other plac	e) Octob 2010	er 16,	Brentwood,		
Baltimore,	permit. Page Department Important: I any injury o		21. Signature of Funeral Service Licens	500	100	2. Name and Addres	ss of Facility St	ewart Fu	neral Home	, Inc.	
	20 E # 9		23a. Part 1. Later the disease, or com	HOUDIT		001 Benn			ington, DC	20019 Approximate	
	Physician/		shoo of heart failure. List only of Immediate Cause (Final	ne cause on each line.			g, such as cardiac t	or respiratory arrest	,	Interval Between Onset and Death	
	Medical Examiner		disease or condition resulting in death)	Due to (or as a con	Disorde sequence of):	: <u>C</u>					
	Lammer	er	Sequentially list conditions,	b. Due to (or us a con							
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	•	thritis						
	icate be executed physician and s the burial-transit	E E	resulting in death) Last	Due to (or as a cor							
760	cate be physic the bu	edical		osteopo	TOSIS						
. Box 68	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transi	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pr 1  Live Birth 2 4  Pregnant at time 9  Unknown	Fetal death 3	☐ Ectopic pregnand ☐ Other (specify) _	ЭУ 		23d. Date of del Month	ivery Day Year	
P.O.	that the		Part II. Other significant conditions of	-					cco use contribute to		
rds,	requires the been signer should be a	ted	Dysphagia, Res	piratory Dis	tress, E	Advanced	Age	V/		robably 4 🖾 Unknown	
ecol	e law re has b	Completed by					<u></u>	24a. Was an autopsy perform	prior to death?	topsy findings available completion of cause of	
Ē	sician: The la certificate ha irector, page 2	Be Co	25. Was case referred to medical			26. Pl	ace of Death (Chec	1 🗌 Yes 2 k only one)	X No 1	2 🗋 No	
Vita	hysici his cer I direct	To B	examiner? 1 ☐ Yes 2 🏞 No		2 ER/Outpatie		er: 4 🖾 Nursing Ho	ome 5 🗆 Residen	ce 6 Other (Spec	ify)	
n of	© 2 € 1 12 Natural 5 ☐ Pending (Month, Day, Year) injury work?										
Division of Vital Records,	Atten ar dear ector: by the	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route City or Town, State)									
_	ne Hospital or n 24 hours afte ne Funeral Diri pleted filled in I	Medical	(Check 2 Medical Exam	sician: To the best of my k iner: On the basis of exami se Practioner: To the best	nation and/or inves	tigation, in my opinio	on, death occurred a	t the time, date and	place, and due to the	cause(s) and manner stated.	
	To the within 2 To the comple		29b. Signature and title of certifier	6	0	29c. Licens		29	d. Date signed (Monti		
Ď	4 /		30. Name and address of person who	Johny Ch		Print)	1005		10/14/	/ 0	
1	4		15245 SH	ADYG ROI		Ro	CKVILL	En	1D- 20	1850	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	ignatur	1		7			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Hilda S. Brittingham 2010 October 2:50 p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wicomico 542 Lin Hill Circle Salisbury Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) Months Days 1 🗆 M 2 🕱 F 73 04/11/1937 **Director** Maryland 214-34-5438 Usual Residence of Decedent Eage 1 and 2 should be filed within 72 hours after deaun who, we then the filed within 72 hours after deaun who, we then thent of Health and Mental Hygiene.

The filem 27 is marked other than "natural", or items 23a or 28a-f show that: If item 27 is marked other than "natural", or items 23a or 28a-f show that: 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 🗆 Yes 2 🏝 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 USA 542 Lin Hill Circle Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14 Bace - American Indian Armed Forces?
1 ☐ Yes 2 🕱 No Black, White, etc. ò 1 Never Married 2X Married Baltimore, Maryland 21215-0036 white 1 Yes 2 No Specify: If Yes. Give Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) accountant accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dorothy Marie White Curtis William Smullen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 542 Lin Hill Circle, Salisbury, MD 21804 Riley Brittingham/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 20c. Location - City or Town, State Springhin' netrony 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/11/2010 Hebron, MD **Gardens** 21. Signati of Funer I Ser <sup>22</sup> Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 1. Enter the disease, or complications that cauck, or heart failure. List only one couse on each ed the death . Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ediate Cause (Final Physician/ ase or condition Medical resulting in death) a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or impry that initiated events and the burial-tran Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ signed by the atte in the past 12 months? Month ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attenduly..., within 24 hours after deeth.

To the Funeral Director: After this certificate has been signal to the funeral director, page 2 should I 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 2 No Certificate: To 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No Natural 5 Pending injury Accident
Suicide
Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 🗌 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) りつろすら and address of person who completed cause of death (Item 23a) (Type, Print) 30. Nan

State Registrar 31. Date filed (Month, Day, Year)

2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Iva В. Bozman 6,2010 0230 M ctober /Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death **Examiner** Salisbury Rehabilitation + Nursing Ctr lisbur Wicomica Social Security Number Year | If Under 03/23/1913 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 214-10-8046 1 □ M 2 T F 97 Months Hours Min Nebraska Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location r than "natural", or items 23a or 28a-f sho 1 ☐ Yes 2 No Directo Maryland Wicomico Salisbury 10e. Street and Number 10g. Citizen of What Country? 21801 USA 5525 N. Upper Ferry Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 1 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify Specify: white þ 3 ₩ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) retail hardware buyer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Beard Bertha Lass 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 is any injury or other trai 5525 N. Upper Ferry Rd., Salisbury, MD 21801 Ronald Bozman/son 20b. Place of Disposition (Name of cemetery, crematory or other place Wicomico Memorial Park Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 10/13/2010 Salisbury, MD 4 □ Donation 5 □ Other (Specify) <sup>22</sup> Name and Address of Facility 1 Home Professional Associaiton 501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pa1-100 disease or condition resulting in death) /Medical Due to (or as a conseque e of): Examiner Pa1-Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence or) The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the pest 12 months? 1 □Yes 2 □No Month Day Year 5 Other (specify) s been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 st autopsy performe 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation ours after death.

leral Director: A
filled in by the ft. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

State

200 Civic

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William H. Robins, M.D.

1 2 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ THOMAS MICHAEL BOARMAN AM OCTOBER 2010 8:16 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHARLES CIVISTA MEDICAL CENTER LA PLATA If Under 1 Year If Under 24 Hrs. . Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex Funeral (Month, Day, Year)
12-16-1970 WASH, D.C Days Hours Min. 39 219-86-2540 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director oortant: If item 27 is marked other than "natural", or items 23a or 28a-f s injury or other traumatic event, the Medical Examiner must be notified MD. CHARLES LA PLATA 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9350 WISE LANE 20646 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No If Yes, Give 1 ☐ Yes 2√ No Specify. Specify: WHITE 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HEAVY EQUIPMENT OPERATOR WASHINGTON GAS 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MARTE MYRTLE SIMPSON WILLARD A. BOARMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT BOARMAN-BROTHER 11500 B.B.FARM PL. NEWBURG, MD. 20664 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

ST. MARY S CEMETERY 10-21-10 NEWPORT, MD. 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. 21. Signature of Juneral Service Lig M00479 LA PLATA, MARYLAND 20646 nter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death allure Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death
Unknown Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed MM 1 🗌 Yes 2 🗌 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 No 26. Place of Death (Check only one) Be မ 4 Nursing Home 5 Residence 6 Other (Specify) 100 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After

236999

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BOARMAN,

ABBAS A. OMAIS CENNA MEDICAL CENTER 1-C POST OFFICE Rd, WALDORF, MD MD OCT 28 2010 32. Registrar's Signature State Registrar

D-57708

only one)

29b. Signature and

title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Departr		ental Hygie	ene 2010	33901
			Hogistia	cate of Death		J. No 0	
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)		2. Date of Death OCt.	19°, 20°10	3. Time of Death
	Medic		Willis Wirt Bennett  4a. Facility Name (if not institution, give street and number)  4b.	City, Town, or Location of Death	001.		10:49A™
	Examin	er				4c. County of Death	_
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	e filed within 72 hours after death with the Maryland tral Hygiene. Ital Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	<b>Funeral Director</b>	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was I	Decedent of Hispanic Origin? (Spec	ifv Yes or No-	14. Race - America	
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ם מ	should and N is ma aumai		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Ad	Idress (Street and Number or Rural	Route Number, C	ity or Town, State, Zip C	ode)
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100	signed by the a	by P	Part II. Other significant conditions contributing to death but not resulting in the under	ying cause given in Part I.	23e. Did toba	cco use contribute to the	e cause of death?
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	his certificate I	Be	25. Was case referred to medical examiner?	26. Place of Death (Check of Death )	only one)		
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1	8 5 € 5		250. Signature and the operation of the particle of the partic	29c. License number	2 2 /2	d. Date signed (Month, D	7 ( / c)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	112210	- VC	wer 19,	2010
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	Stat	e	31. Date for Month 18, 2010 32. Begistrar's Agnatus			7	- /
	Registra	ar					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2010 OCTOBER BASIL **EVERALD** COLLINS 9:35 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S 11111 TADMORE PLACE UPPER MARLBORO Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 ₹ M 2 □ F MARCH Yay, Yar) 1933 SAMACIA 053-36-4696 77 Director Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 Yes 2 ☐ No MDPRINCE GEORGE'S UPPER MARLBORO 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 11111 TADMORE PLACE 20772 USA death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc Completed by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or 1 Yes Maryland 21215-0036 BLACK 1 ☐ Yes 2 No Specify. 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 4YRS HORTICULTURE GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ COLLINS other traumatic BARKER CLEMENTINA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>JANICE T. COLLINS/WIFE</u> TADMORE PLACE UPPER MARLBORO, MARYLAND 20772 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Remova 4 Donation 5 Other (Specify) 10-16-2010 | WASHINGTON, DC ROCKCREEK CEMETERY 22. Name and Address of Facility J. B. JENKILS FUNEKAL HOME, INC. 21. Signature of Funeral S. LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ FAILURE TO THRIVE Medical resulting in death) Due to (or as a consequence of) Examiner GASTROINTESTINAL STROMAL TUMOR Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Exami attending physician and for use as the burial-transit GASTRIC CANCER 5 MOS Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death signed by the a d be detached f 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 🗌 Yes 2 🗍 No 3 🗌 Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? certificate 2 🛚 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one Other: 1 ☐ Yes 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of I Director: After to d in by the funera Certificate: 28c. Injury at 28d. Describe how injury occurred 1 💹 Natural 5 Pending injury 1 Yes 2 🗌 No Accident Investigation 6 Could not be 2 ☐ Accider 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

To the Hospital or Attending Physician: The law requires Records, of Vital Division 24 hours

State

DHIMITRI GROSS M.D. 31. Date filed (Month, Day, Year, OCT 1 5 2010

29b. Signature and title of certifie

3261 OLD WASHINGTON ROAD # 3010 WALDORF, MARYLAND 20602 32. Registrar's Signature racke

Certifying Nurse Fractioner: To the best of my knowledge, dea

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Medical

29a. Certifier (Check

1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

OCTOBER 13, 2010

29c. License number

D0055146

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Monto be 2ªy Physician/ Brenda Ann Crawford Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Hagerstown Washington County Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number **Funeral** Jan 14, Year 955 1 □ M 2 🖵 F Months Hours Min. Maryland 55 Yrs. 215-74-8865 Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10c. City, Town or Location should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 XYes 2 No Hagerstown Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A 21740 11 W. Baltimore St. Apt. 127 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. ò 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Completed 3 Divorced 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Constance Zimmerman ည William Clopper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Beverly A. Loveless (Sister) . Page 1 and 2 sl tment of Health a tant: If item 27 is 1027 Florida Ave. Hagerstown, Md. 21740 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If ite any injury or ot Oct. 19, 2010 1 🗌 Burial 2 🛣 Cremation 3 🗌 Removal from State Smithsburg, Md. Smithsburg Crematory 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. MO1414 J.L. Davis Funeral Home Smithsburg, Md. Ala. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final secu div Physician/ disease or condition resulting in death) Medical Examiner TIVE if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Physician/Medical Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Month Year Day 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by OBSTIUCTIVE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? CBESIT MORBIO 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 2 1 No 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at work? 1 ☐ Yes 2 ☑ No 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 1 Natural 5 Pending Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, within 24 hours after de
To the Funeral Directo
completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 10061117 rulo Dever 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. antietan St. Hageistown niels

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1459M 2010 Octobe <u>Shelva Jean Lorraine DORSEY</u> Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Washington County Hospital Hagerstown <u>Washington</u> 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🗓 F Months Hours Min. (Month, Day, Country) 71 **Director** Maryland 4 1938 215-36-5959 Nov. Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location 1 ☐ Yes 2X No Maryland Washington Fairplay ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18038 Lappans Road 21733 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant; If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 11 0 Homemaker Her own home other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marshall Durboraw Dorothy Giffin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7539 Sharpsburg Pike, Boonsboro, Maryland 21713 <u>Susan Stoy - Daughter</u> 20b. Place of Disposition (Name of semetery, crematory or other place)
Salem Evangelical
Lutheran Ch. Cemetery 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of h Important; If ite any injury or ot 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bakersville, Maryland 10/19/10 Signature of Funeral Service Licen 22. Name and Address of Facility Minnich Funeral Home 415 Ε. Wilson Blvd. Hagerstown, Md. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease. Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Daser and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir physician and the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Physician; The law requires that the death certificate be executed attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy

5 Other (specify) \_\_\_\_ in the past 12 month Month Dav Year Pregnant at time of death signed by the a 1 ☐ Yes 2 € g ☐ Unknown Part II. Other significant conditions contributing to geath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy page death? 2 No 1 Yes 2 No Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 2 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c, Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending injury work? 1 ☐ Yes 2 ☐ No 1 Natura 5 Pendina s after death. 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number filled in by determined City or Town, State 24 hours Funeral Medical 29a. Certifier Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the lawithin 2 To the law 29b. Signature and title of certifier

State Registrar

Box 68760

P.O.

Records,

Division of Vital

31. Date filed (Month, Day, Year)

W

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ X FODE 1005M Maranda Grace DeLauder Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Hagerstown Washington County Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Min. March 27, Year) 1 M 2 X Maryland 3 2007 Director 220-77-1269 Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 USA 1013 Georgia Avenue 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 0 1X Never Married 2 ☐ Married Completed by Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify. and Mental Hygiene. is marked other than "natural", 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) none none none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Alison Campbell Alan Craig DeLauder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1013 Georgia Avenue, Hagerstown, Md. 21740 Alison DeLauder - mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 Cremation 3 Removal from State Williamsport, Md. 4 ☐ Donation 5 ☐ Other (Specify) Greenlawn Mem. Park 10/16/10 22. Name and Address of Facility 21. Signature of Funeral Service Licens MINNICH FUNERAL HOME alest 415 E.Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. mode of dving, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a co Examin that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No. Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 ☐ Yes 2 D signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 Tes Completed has been signed to the property of the propert 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page perform 2 🗌 No 1 🗌 Yes \_\_ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 🗌 Yes ER/Outpatient 3 DOA ည 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Lath 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

Box 68760 P.O. Records, Division of Vital Hospital or Attending 24 hours after death.
Funeral Director: After eted filled in by the fun

State Registrar

Medical

29a. Certifier

(Check

only on 29b. Signatu

DHMH 17 Rev 7/2009

eath (Item 23a) (Type, Print)

completed cause of

Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 Clara T. DeMarzo October 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Crofton Care & Rehabilitation Center Crofton Social Security Numbe If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth Funeral Days New York Director 057-12-2944 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 ☐ Yes 2 X No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 USA 701 Ballast Way 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 1 and 2 should be filed within 72 hours after file theath and Mental Hygiene.

item 27 is marked other than "natural", 3 X Widowed 4 □ Divorced White Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Bookkeeper Finance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Gillette Diego Lodico 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary D. Funk/ Daughter 1814 Stonegate Ave., Crofton, MD 21114 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. : 10/15/10 Silver Spring, MD 21. Signature of And Sprice Jensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Intracerebral bleed Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Due to jor as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe this certificate has 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) Hospital 2 No 1  $\square$  Yes <u>|</u>2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 20 Name and address of person who completed dause of death (Item 23a) (Type, Print) Defense Hay, Crofton, MO21114

Registrar

DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician  $P^{M}$ Robert Weldon Davidson October 0 16 2010 1238 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner E1kton Ceci1 Union Hospital 8. Date of Birth (Month, Day, Year) June 17, 1924 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral Min 1 X M 2 □ F Months Days Hours 86 Pennsylvania 229-16-4457 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examination with the political Director 1 Yes 2 □ No Maryland Ceci1 Elk Mills 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1 and 2 should be filed within 72 hours after death with 1 Health and Mental Hygiene. em 27 Is marked other than "natural", or items 23a or 7 652 Elk Mills Road 21920 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? World 1 MYes 2 □ No If Yes, Give War II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married IT Yes, Give War II Baltimore, Maryland 21215-0036 1 ☐Yes 2 🗓 No Specify. à Specify: 3 X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Refrigeration/ Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Air Conditioning 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George R. Davidson, Sr. A. Susan McCafferty ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is r any Injury or other traur Valerie L. Davidson/Daughter P.O. Box 83, Elk Mills, MD 21920 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State October 18 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State R. A. Ferris & Co., Inc. 4 ☐ Donation 5 ☐ Other (Specify) West Chester, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is its and or injury that it is its and or injury that is its and or injury that is its and or injury that is its and or injury that it is its and or injury that it is its and or injury that it is its and or injury that it is its and or injury that it is its and or injury that it is its and or injury that it is its and or injury that it is its and or injury that it is its and or injury that it is its and or injury that it is its and or injury that it is its and or injury that it is its and or injury that it is its and or injury that it is it is its Examiner The law requires that the death certificate be executed burial-tran and that initiated events resulting in death) Last P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 🗆 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) s been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy perform this certificate 1 □Yes 2 2 1 □Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA မ After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation within 24 hours after deam.

To the Funeral Director A 1 ☐ Yes 2 🗆 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated.

State Registrar

" OCT 28'2010"

Server 32. Registrer's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 09 2010 0920 ROBERT F. EDENHART Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner WMHS-Regional Medical Center Allegan umbertana 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours 08/08/1920 WEST VIRGINIA Director 220-10-0629 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director WV MINERAL RIDGELEY 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a once. Funeral 26753 U.S.A. 37 THIRD AVENUE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. ģ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: WHITE 3 X Widowed 4 Divorced Completed WWII Year or Dates. 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) RETAIL GROCERY STORE MANAGER 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MABEL E. BRANT MICHAEL F. EDENHART 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA KINES / DAUGHTER P.O. BOX 131, RIDGELEY, WV 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) CUMBERLAND CREMATORY 09/07/2010 CUMBERLAND, MD 21. Signature of Funeral ervice Licenses 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. ga 21502 202 GREENE STREET, CUMBERLAND, MD 23a. Part Penter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Seizure disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Do Sequentially list conditions, if any leading to inspect cause. Enter Underlying Examine Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the buria Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Pregnant at time of death 5 Other (specify) Year 1 ☐ Yes ∠ ☐ g ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No this certificate has page 2 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Be 2) No Hospital Other: ျှ 1 🗌 Yes 1 🖾 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After injury 1 🖾 Natural 5 Pending Accident Investigation 24 hours after deat Funeral Director: the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. completed filled in by determined City or Town, State, Medical 29a. Certifier Zertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Tre

State Registrar AVO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October  $14^{\text{Day}}$ 8:25 AM 20 lo Staley Forcino Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 13001 Blue Ridge Road Washington Hagerstown If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1 M 2 X F Months Days Hours Min Director Maryland 214-34-9287 Ian. Usual Residence of Decedent 28a-f show 10a. State Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Washington Hagerstown 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? with Funeral 13001 Blue Ridge Road 21742 U.S.A. items ? death \ 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō 72 hours after þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed er than "natura , the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) RN Nursing is marked other aumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 27 is marked Lewis Hillard Staley Kathryn McAllister 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. James S. Forcino/Husband 13001 Blue Ridge Road, Hagerstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 

Burial 2 

Cremation 3 

Removal from State 4 □ Donation 5 🛣 Other (Specify) Entombment Rest Haven Cemetery 10/18/2010 Hagerstown, MD . Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Onset and Death Immediate Cause (Final Physician/ ocardial disease or condition da Medical resulting in death) as a consequence of) Examiner cirrhos month Sequentially list conditions, Physician/Medical Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or linjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and the for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Day 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an has autopsy To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No 은 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, 24 hours Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) 10/15 M.O. 00047234 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kelli A. Strauss MO Avenue Swite 101 Hagerstown 13414 Pennsylvania

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

egistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Phillip Charles F		1- For State	State of Maryl		artment of		d Mental F		201	0 33910
Physicia Medical Exami	an/	Registrar  1. Decedent's Name (First, Mic Phillip Charle	idle,Last)					2. Date of Deat Month October 7,	h Dav Year	3. Time of Death 1204 hrs
		4a. Facility Name (if not instituted) 7411 Dunmanway	S F I amm tion, give street and n	umber)		4b. City, Town, or I	Location of Deat		4c. County of Baltimore	
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days		<b>-</b> →		Birthplace (State or Foreign
Director	}	174-46-6600 Usual Residence of Decedent	1 X M 2 F	ī	55 Yrs			03/20/	/1955	Country) PA
1 low any		10a. State 10b. Count			, Town or Locat	ion				10d. Inside City Limits  1 Yes 2 No
Maryland 28a-f sh d at onc	Director	MD Balt.  10e. Street and Number	imore	Dunc	dalk	10f. Zip Code		10	Og. Citizen of Wha	- 21
with the s 23a or		7411 Dunmanwa		cedent Ever in U	.S. 13. Wa	21222 as Decedent of His	panic Origin? ( \$	Specify Yes or No-	U.S.	A. American Indian, Black,
r death v or item	Funeral	1 Never Married 2 X	1 Yes	2X No	lf Y	es, specify Cuban	, Mexican, Puert		White,	
ours afte atural",	à	3 Widowed 4 5. Decedent's Education (Sp	Divorced If Yes, Give Ye or Dates: Decify only highest gra		16a. Deceder	Yes 2 X No nt's Usual Occupati lost of working life.	ion (Give kind of		16b. Kind of Bus	White iness/Industry
136 hin 72 h e. than "n than "n	Completed	Elementary/Secondary (0-12	2) College (	1-4 or 5+)				med)	MD Oi	
15-0036 filed within 7 I Hygiene. d other than		17. Father's Name (First, Midd			L OLLBI		18.Mother's Nam	e (First, Middle, N	Maiden Surname)	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	Phillip George 19a. Informant's Name/Relatio	nship (Type, Print)		19b. Mailin	g Address (Street		arl Good Rural Route Num		, State, Zip Code)
MD and 2 sho fealth and ttem 27 is traumati		Mary Arndt/sis 20a. Method of Disposition			Place of Dispos	sition (Name of cen	netery,	Reister Date	Stown N 20c. Location -	AD 21136 City or Town, State
Baltimore, pernit. Pages I as Department of Her Important: If ite		1 Burial 2 Cremati 4 Donation 5 Other		Tom State	crematory or ot	remation.	Inc. 10	/11/2010	Hampste	ead. MD
Balti permit. Departi Import		21. Signature of Funeral Servi	1 /		22. N	lame and Address	of Facility Pr	itts Fun	eral Hom	ne & Chapel, PA
Physician / /Medical	1	23a. Part 1. Enter the disease, failure. List only one cause	se on each line.			he mode of dying,	such as cardiac	or respiratory arre	est, shock, or hear	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disea or condition resulting in death)		unshot Wour a consequence o						Dean
	Je	Sequentially list conditions, if any, leading to immediate		a consequence o	of);					
ted nsit	Examiner	(Disease or injury that initiated events resulting in death) Las	1 °	a consequence o	of):				-	
), be executed sician and urial - transit	dical	UNPENDED	AMENDED							
Records, P.O. Box 68760, The law requires that the death certificate b locate has been signed by the attending physic page 2 should be detached for use as the bur	siciar	IF FEMALE: 23b. Was decedent pregnant in past 12 months?  1 Yes 2 No 9 L	1 Live	nant at time of de	2 🔲 Fe	etal death 3 [ ther (Specify)	Ectopic pregr	ancy	23d, Date of d Month	delivery Day Year
P.O. E	by Phy	Part II. Other significant cond	ditions contributing	to death but not r	resulting in the I	underlying cause g	iven in Part I.		obacco use contrib	oute to the cause of death?  Probably 4 Unknown
of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by tuneral director, page 2 should be detach.	Completed			_					sy pr	Vere autopsy findings available ior to completion of cause of sath?  Yes 2 No
	å	25. Was case referred to medi examiner?	cal Hospital:	Inpatient 2	ER/Outpatien		of Death (Check		Residence 6	Other: Scene
n of V ding Phy n. After thi funeral d	on: To	1 ✓ Yes 2 No  27. Manner of Death  1 Natural 5 Death	(Mon	e of Injury th Day, Year) 2010	28b. Time of 1204 hrs	Injury 28c. Injur	ry at Work?		now injury occurre	
Division of Vital  To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certif completely filled in by the funeral director.	ertification:	2 Accident In	vestigation	ce of Injury - At h	ome, farm, stre	et, factory, office b	res 2 ✓ No uilding, etc.	or Town, S		r or Rural Route Number, City
the Hosp hin 24 ho the Fune npletely fi	Medical C	Chook only	Physician: To the be xaminer: On the basis	of examination a						
	Me	29b. Signature and title of cert	and manner	stated.	2	29c. Licenso				d (Month, Day, Year)
MIL		30. Name/and address of pers	on who completed car	use of death (Iten	n 23a)	O.C.I	VI.E.		October 8, 2	
St	tate	Russell Alexander N 31. Date filed (Month, Day, Yea		Medical Exar		Penn Street,	Baltimore, N	/ID 21201		
Di-		OCT T	2 2010 L Z	10	B L	. 11				

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oward William	·	1- For State	e of Maryland		rtment of tificate of		d Menta		20 i	0 33911
Physicia		Registrar 1. Decedent's Name (First, Middle, L	.ast)		tinouto or	- Boutin	<del></del>	2. Date of Deat		3. Time of Death
ledical Exami		Howard	William F	loyd				Month October 1,	Day Year , 2010	1830 hrs
)		4a. Facility Name (if not institution,	•	ber) 4b. City, Town, or Location of Death			Death	4c. County of		
~~~		Prince George's Hospita				Cheverly			Prince Ge	-
Funeral Director				Age (In yrs. Ia	ast birthday)	If Under 1 Yes Months Day		24Hrs. 8. Date of Birt	th(MM/DD/YYYY)	Birthplace (State or Foreign
Director		420 (41 1000	X M 2 F	6	5 Yrs.				9, 1945	Pennsylvania
any	ŀ	Usual Residence of Decedent  10a. State 10b. County		10c. City.	Town or Locati	on				10d. Inside City Limits
		DC					Washin	igton		1 X Yes 2 No
Aaryland 28a-f show 1 at ouce.	Director	10e. Street and Number				10f. Zip Code			Og. Citizen of Wha	at Country?
th the Maryland 23a or 28a-f sho notified at once.	ä	3222 E. Street	SE Ant	# <b>A</b>		,	20019		United	States
with ns 23. be no	uneral	11. Marital Status	12. Was Decede	nt Ever in U.		s Decedent of Hi	spanic Origin	n? ( Specify Yes or No	- 14. Race -	American Indian, Black,
death or ite	Fun	1 X Never Married 2 Marri	ied Armed Force	s? 2 🗓 No	If Y	es, specify Cuba	n, Mexican, f	Puerto Rican, etc.)	White,	
s after	à		ced If Yes, Give Year or Dates:			Yes 2 X No			Specify:	Black
hours after "natural", Examiner		15. Decedent's Education (Specify Elementary/Secondary (0-12)				t's Usual Occupa ost of working life		nd of work done ise retired)	16b. Kind of Bus	iness/Industry
36 hin 72 than '	ompleted	10th	College (1-4 o	)I 5+}	Cubata	ance Abu	ac Cor	.maalaw		Private
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	S	17. Father's Name (First, Middle, La	ast)		Substa	ince Abu		Name (First, Middle, N	Maiden Surname)	TIIVate
215 be file ntal H rked c	a				uı	ık				unk
nore, MD 21215-0036  ages I and 2 should be filed within 72 hours after death with the Maryland  nt of Health and Mental Hygiene.  It: If litem 27 is marked other than "natural", or items 23a or 28a-f shother traumatic event, the Medical Examiner must be notified at once	은	19a. Informant's Name/Relationship	(Type, Print)		0	•		er or Rural Route Num	nber, City or Town	
MD and 2 sho m 27 is m 27 is		Valencia White/	Daughter			E Street		Apt. #4 Wa		
Baltimore, permit. Pages I an Department of Hea important: If iter		20a. Method of Disposition  1 Burial 2 A Cremation	3 Removal from		crematory or oth			Date October 15	i	City or Town, State
imc Page ment tant: or of		4 Donation 5 Other Spec				Cremato	ry [	2010	Clint	on, Maryland
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27	- [	1. Signature of Funeral Service of	ensee	IM	>	ame and Addres	·			lome, Inc.
Physician	2, 4	23a Part I. Enter the disease, or co	mplications that cause	ed the death				oad NE Was		
/Medical		fallure. List only one cause on	each line.					and an isophiatory and	oon, orrown, or reco	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cor			ovasculai Di	sease			
		Sequentially list conditions,	b							
	ie.	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cor	nsequence o	f):					
=	Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cor	nsequence o	f):					
be executed sician and urial - transit			d	· · · · · · · · · · · · · · · · · · ·				<del></del>		
be es	edical	UNPENDED	AMENDED							
Box 6876( e death certificate the attending phy ed for use as the t	Ž	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outo			tal death 3	Ectopic	pregnancy	23d. Date of o	delivery Day Year
X 6.	icia	past 12 months?	4 Pregnant	at time of de		ner (Specify)		p. og. ia. io,	in and	54, 104
Bo le deat the at	Physician/M	1 Yes 2 No 9 Unkno	9 OHKHOWH							
P.O. Es that the ces that the ces detached	by P	Part II. Other significant condition		ath but not n	esulting in the u	nderlying cause	given in Part	t I. 23e. Did to		oute to the cause of death?  Probably 4 Unknown
S, F quires en sign lid be	ed	Chronic alcohol abbuse	=					24a. Was		
cords, law requir has been s	ple							autop	sy pr	Vere autopsy findings available rior to completion of cause of eath?
tal Recc cian: The lav certificate ha	Completed							1 ✓ Yes		Yes 2 No
ital lician: ician: s certifi rector,	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpa		leno i ii i		i Othor:	Check only one)		7
of Vi Physicer this eral dir	은	1 Yes 2 No 27. Manner of Death	28a. Date of li		ER/Outpatient 28b. Time of I		ury at Work?		Residence 6 how injury occurre	Other:
Division of Vital Records, P.O ral or Attending Physician: The law requires that its after death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact	Certification:	1 Natural 5 Pendin	(Month, Day	y,Year)	200. 7	``	Yes 2	1	now injury occurre	•
r Atte	licat	2 Accident Investig	28e Place of	f Injury - At h	ome, farm, stree	et, factory, office	building, etc.	. 28f. Location (	Street and Numbe	er or Rural Route Number, City
Divipital or ours after Dir filled in	E.	3 Suicide 6 Could redeterm						or Town, S		
Hosp 24 hou Fune: tely fi		29a. Certifier 1 Certifying Physician						ce, and due to the caus		
Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physomopletely filled in by the funeral director, page 2 should be detached for use as the b	Medical	one) 2 Medical Exami	ner: On the basis of e	xamination a	ınd/or investigat	ion, in my opinio	n, death occ	urred at the time, date	and place, and du	ue to the cause(s)
	ž	29b. Signature and title of certifier		_ /	1 -		se number		1	ed (Month, Day, Year)
		ann	NU	//		0.0	.M.E.		October 4,	2010
2		30. Name and address of person w Zabiullah Ali, M.D. As	101			n Street, Bal	Itimoso M	ID 21201		
	oto.	31. Date filed (Month, Day, Year)	ssistant Medical	traris Signati	re ·	n Sueet, Da	idinole, M	ID 2 12U		
Si Regis		OCT 1 5 2010	Prana .	A. A	arkel					

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Viola Harrington Fitzpatrick 12:54 Рм October 0 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Rockville Shady Grove Adventist Hospital 8. Date of Birth (Month, Day, Year January 18, 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Months Days Hours Min. New Haven, CT 046-24-1593 81 Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Gaithersburg 1 X Yes 2 No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20877 419 Russell Avenue, #512 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Library of Congress Elementary/Seconday (0-12) College (1-4 or 5+) Senior Editor should be filed with and Mental Hygien 7 is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edith Andrews Edward O. Harrington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 3314 Belleview Avenue, Cheverly, MD 20785 Kristine J. Fitzpatrick / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 

Burial 2 

Cremation 3 

Removal from State 10/14/2010 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 RAY Roos 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ RESPIRATORY disease or condition MINUTES Medical resulting in death) Due to (or as a consequence of) **Examiner** OBSTRUCTIVE DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of PNEUMONIA Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed DAYS attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed' certificate 2 🗌 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5  $\square$  Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse, Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

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Registrar DHMH 17 Rev 7/2009 29b. Signature and title

ZHANG

31. Date filed (Month, Day, Year) 0CT 1 5 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar' Signature

MD

29c. License number

D65132

9901 MEDICAL CENTER DRIVE ROCKVILLE MARYLAND

29d. Date signed (Month, Day, Year) OCTOBER 12 2016

20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0830 M 2010 George W. Fisher Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death TENINSULA BEGIONAL HICONE 3A4364W Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Age (In yrs. last birthday 9. Birthplace (State or Foreign Days 1 ▼M 2 □ F Months Min. Hours 11/11/8/11 949 **Director** 222-34-9687 60 Delaware Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No Delaware Sussex Laure1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19956 U.S.A. 31723 Old Hickory Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 X Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Educational Institute Shipper / Receiver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Earl Bryan Fisher, Sr. Bertha Mae Hartman I and 2 should b FHealth and Me Item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr David M. Fisher / Son 426 Ocean Court, Milton, DE 19968 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bethel Meth. Cemetery 10/16/2010 Lewes, Delaware 21. Signature of uneral Service Licens 22. Name and Address of Facility arsell Funeral Enterprises, Inc. Part 1. Enter the shock, or heart (a atisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, all of e. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ASCVD disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has performed Yes 2 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 KER/Outpatient 3 IDOA e Hospital or Attending Phys 124 hours after death. e Funeral Director: After this leted filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes X Natural 5 Pending Division 2 Accident
3 Suicide Investigation 2 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 124 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated соmpleted (Check 3 🖵 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 10/10/10

Box 68760

P.O.

of Vital

DHMH 17 Rev 7/2009

Registrar

100 E. CARNOUST. SAlisbury M.D. 21801

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

00

Registrar's Signature

MRISTUNHER

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14

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/  $16^{\text{Day}}$ 2010 Monaford Lee GARDNER October 6:50 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Keedysville Washington 4033 Chestnut Grove Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** 1 ፟ M 2 ☐ F Days Feb. 13, 1926 220-16-3691 Maryland 84 Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County t0a. State 10d. Inside City Limits by Funeral Director Maryland Washington Keedysville 1 ☐ Yes 2X No 10e. Street and Number 10g. Citizen of What Country? U.S.A. 4033 Chestnut Grove Road 21756 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mential Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. the Manager 1990. Elementary/Seconday (0-12) College (1-4 or 5+) supervision maintenance Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Garland Abraham Gardner unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4037 Chestnut Grove, Keedysville, Maryland 21756 Erle S. Gardner - son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 20, Hagerstown, Maryland 4 Donation 5 Other (Specify) Signature Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ prostate metastatic disease or condition ears Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Yes 2 No 1 Yes 2 Unknown g Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. After this certificate has been signed I funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, atheroscierotic heart disease 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an chronic obstructive lung disease autopsy performed Yes 2 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Medical Certificate: 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Contree Kuther Sands of D47451 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - Sands no Hospice of Washington County, 747 Northern Avenue - Sands no Hospice of Washington County, Hagerstown, Maryland 21742 31. Date filed (Month, Day, Year) State OCT 13 Registrar

DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Cer	tificate o	f Death			Reg. No.		
Physicia		Decedent's Name (First, Midd)	e,Last)					2. Date of	of Death		3. Time of Death
Medical Exami		John Ruperto	Gonzalez			Month Day Year October 12, 2010 2					2347 hrs
		4a. Facility Name (if not institution		mber)		4b. City, Town, or Location of Death				c. County of Deat	th
		Washington County H	lospital			Hagerstow	'n		١	<b>Vashington</b>	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Ye	ar If Und	er 24Hrs. 8. Date	of Birth(MM		rthplace (State or
Director		E71 62 001E	1XXM 2 F	62	Yrs	Months Da	ys Hour	s Min.	:1 22	Forei	onew York
	ŀ	571-62-0815 Usual Residence of Decedent	14-1-141 2 1	63	118	°		Apr	il 22,	1947	Mew TOLK
á	ŀ	10a. State 10b. County		10c. City,	Town or Local	tion	-				10d. Inside City Limits
		Manual and Line	ما ما ما ما ما ما ما ما ما ما ما ما ما م		7.7.2.7	1					1 Yes 2 XX
ylanc ylanc	흱	Maryland Was	hington		MIT	liamspo	<u>rt</u>		10g Cit	izen of What Cou	
ne Maryland or 28a-f show any fied at once.	Director								Tog. Oil		•
th the		14501 Acorn W					21795		٠	US	
th wi	Funeral	11. Marital Status  1 Never Married 2 XXM		edent Ever in U. orces?				gin? ( Specify Yes n, Puerto Rican, et		14. Race - Ame White, etc.	rican Indian, Black,
r dea or it	킚		1 Yes	2 X No		·				0	***
s afte	<u>a</u>		orced If Yes, Give Year or Dates:					Puerto R		Specify:	White
hour	Completed	15. Decedent's Education (Spe			during m	nt's Usual Occup nost of working li	ation (Give e. DO NOT	kind of work done use retired)	100.	Kind of Business	industry
36 n 72 nan "iical	흥	Elementary/Secondary (0-12)	College (1	-4 or 5+)							
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ÿH-√ 8 4 ½ 4	ate	30. Name and address of persor Patricia Aronica-Polla 31. Date filed (Month, Day, Year)	k MD. Assista		Examiner			altimore, MD			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [ State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Robert F. Garbarini 2:30 PM 2010 October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Renaissance Gardens at Riderwood Silver Spring Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Days Hours Min. 142-16-4949 91 Director 31,1918 Woodside, NY December Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits be filed within 72 hours after death with the Maryland 10c. City. Town or Location Director 1 Yes 2 X No Maryland Prince George's Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 3160 Gracefield Road, ET 2230 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Aerospace and Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Aerospace Executive Communications 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 6 permit. Page 1 and 2 should be to Department of Health and Menta Important: If item 27 is marked any injury or other traumatic events. Adeline Regalia Anthony M. Garbarini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura M. Donnelly / Daughter 4421 Underwood Street, University Park, MD 20782 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 10/14/2010 Alexandria, Virginia Metropolitan Crematory 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician. Arteriosclerotic Cardiovascular Disease disease or condition resulting in death) Unknown Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiates acoust. Examine Due to (or as a consequence of): signed by the attending physician and d be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 1 ☐ Yes 2 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Alzheimer's Disease 1 Yes 2 No 3 Probably 4 X Unknown neec Chronic Kidney Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 🖾 Nursing Home 5 🗌 Residence 6 🗍 Other (Specify) 1 🗌 Yes 2 🔀 No 유 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred X Natural 5 Pending Accident Investigation after death Director: / 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Eileen Gemmell, 3160 Gracefield Road, Silver Spring, MD 20904 Eileen Gemmell, 32. Registraris Signature 31. Date filed (Month, Day, Year 2010 OCT 1 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 October A M David Grosso 0654 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Ceci1 E1kton Union Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F AUG 7. 1961 Days Hours Pennsylvania Director Yrs 179-58-3331 49 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Ceci1 Charlestown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 211 Market Street 21914 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. þ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Anthony Grosso Rae Scotti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony Grosso/Father 2345 Hillside Lane, Aston, PA 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State SS Peter and Paul Cemetery crematory or other place Cemetery 4 Donation 5 Other (Specify) 19, 2010 Marple, PA 21. Signa ure of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ AnoxIL tracephalopath disease or condition Medical resulting in death) Examiner Cardionulmonay Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Withdrawa Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Day Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes 2 No မ 1 Nation 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28c. Injury at work? 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 1 S Natural 5 Pending injury 1 Tyes 2 🗌 No Investigation Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, gearn occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 048 er 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bow State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Harry E. Griffith /Medical 4c. County of Death HARF 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Bel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Year) 1**√** M 2□ F 84 Months Days Hours Min. 220-18-8144 13, **Director** MD Sept. 1926 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show d other than "natural", or items 23a or 28a-f shovevent, the Medical Examinar must be notified at Director 1 Yes 2 □ No MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 261 Beckenham Circle Unit 302 21014 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1945— Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian 1 Never Married 2 Married 1 □Yes 2 No Specify: White If Yes, Give Year or Dates: 1945 δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Salesman Oil n and Mental Hygi 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gertrude C. Gessner Harry E. Griffith ္ရ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 261 Beckenham Circle Unit 302 Bel Air Md 21014 Ethel M. Griffith/Wife 27 permit, Pages 1 an Department of Heal Important: If item 2 any injury or other injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. John the
Baptist Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 2010 4 ☐ Donation 5 ☐ Other (Specify) New Freedom, PA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 24 N. Second St., New Freedom, PA 17349 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** CHRONIC OBSTRUCTIVE LUNG DISEASE, ENDSTAGE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit be execute Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) P.0. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ FIBROSIS. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? HYPERTENSION 24a. Was an autopsy performed? certificate 1 Yes 2 No 1 ☐Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) ie Hospital or Attending P n 24 hours after death. ie Funeral Director: After t 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a, Certifier completely (Check only one) within 2. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) rellijain 145344 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 632 HAVRE MD 32. Registrar's Signi State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Milton Andrew Hill October 2010 1407 hrs. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Montgomery General Hospital Onley Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Yee 1963 **Funeral** 1 X M 2 D F Months Days Hours Min. 47 North Carolina 579-92-5016 Director October Usual Residence of Decedent shov or 28a-f shov notified at 10b. County 10a. State with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits 1XXYes 2 ☐ No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 3937 Tynewick Drive 20906 United States within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Black, White, etc. ö þ 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural" Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. ementary/Seconday (0-12) College (1-4 or 5+) 11th grade Plumber Construction of Health and Mental Hygie if item 27 is marked other r other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) e 1 and 2 should be fill of Health and Mental fitem 27 is marked o မ Joseph Thomas Johnnie Mae Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3937 Tynewick Drive; Silver Spring, Maryland 20906 Karen Marie Milton Hill (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State of 1 ☐ Burial 2 XCremation 3 ☐ Removal from State ō Department of Important: If any injury or Chesapeake Crematory, Inc. Beltsville, Maryland 4 Donation 5 Other (Specify) ignature of Funeral Service Livenset 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
BOAYS Immediate Cause (Final ANOXIC ENCEPHALOPATHY Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 3 YEARS CARDIOMYCPATHY Sequentially list conditions Examine Quarto for as a por securior of cause. Enter Underlying Cause (Disease or linjury that initiated events Physician: The law requires that the death certificate be executed and -tran resulting in death) Last Due to (or as a consequence of) burial-1 attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Dav Year Pregnant at time of death signed by the a Yes 2 No g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No After this certificate 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 X No Other: 욘 1 Maligner | 1 Inpatient | 2 □ ER/Outpatient | 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify) e Hospital or Attending Phys n 24 hours after death. e Funeral Director; After this bleted filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) myr, Mo OCTOBER 12, 2010 D 23630 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 16220 FREDERZEK ROAD, SUZTEZIZ, GATTHERSBURG, MARYLAND 20877 FRANK J. MAYO, MO 31. Date filed (Month, Day

Registrar

OCT 1 5 2010

32. Registrar's S

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			ForState	State of Ma	arylan		artmer <i>tificat</i>			and M	1ental Hy		2010	33920	
		n	Registrar  1. Decedent's Name (First, Middle, Las	t)		Cer	liiicat	e oi L	eaur		2. Date of De	Reg. No.	.010	3. Time of Death	
	Physicia Medic		DERRICK		H	AIRSTO	1				Month OCTOB	Day		6:30 P M	
	Examir		4a. Facility Name (if not institution, give HOLY CROSS HOS						Location o			4c.	4c. County of Death MONTGOMERY		
	Funeral Director		212-00-4910	TX	(In yrs. 1 38	ast birthday) Yrs.	If Unde Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da NOV •	th 20 19		thplace (State or Foreign untry) SHINGTON, DC	
	show d at	tor	Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits	
	e Mary r <b>28a-f</b> notifie	Funeral Director	MD PRINCE G	EORGE'S	GRI	EENBEL'		0.1						1 ¥ Yes 2 □ No	
	with th	eral	8145 MANDAN TERR	ACE			10f. Zip		770			US	zen of What Co	ountry?	
	tems er mu	Ē	11. Marital Status	12. Was Decedent E	ver in U.S	S. 13. V	Vas Deced			gin? (Spe	cify Yes or No- Rican, etc.)		14. Race - Ame	rican Indian,	
36	after d al", or i xamin	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 😾 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ If Yes, Give	No		Yes, spec				Rican, etc.)	l i	Black, White Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Black, Bla	e, etc. LACK	
9-0	hours natura Jical E	lete	15. Decedent's Ed			16a. Deced	lent's Usua	al Occupa	ition			16b. Kir	nd of Business	Industry	
21215-0036	within 72 giene. er than " , the Mec	Completed	(Specify only highest gra	College (1-4 or 5	+)	(Give kind of work done during most of workin life. DO NOT use retired) DISABLED					ng		NE	•	
Maryland	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)  RICHARD M. HAIRS	STON						er's Name NELLE	(First, Middle,	Maiden S GRUDE			
	d 2 shoul alth and 1 27 is m		19a. Informant's Name/Relationship (TyRICHARD M. HAIRS	•	R	19b. Mailin 8145	g Address MAND	(Street a	nd Numbe ERRAC	er or Rura CE GR	Route Numbe	er, City or T	Town, State, Zip RYLAND	20770	
Baltimore,	Page 1 and ment of He and till item ant; If item ant; ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary or other ary		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State		Place of Dispo					ate		cation - City or		
Itim	Pa ant r		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licens	v)	GA'	TE OF 1			ME .					ING,MARYLAND AL HOME,INC.	
Ba	permit. Departr Imports any inji		Juano Z	Call	eur									LAND 20785	
I	Physician/ Medical		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line  CARDI	OPUL	MONARY			, such as o	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death	
	Examiner	_	Sequentially list conditions,		MYO	CARDIA	L IN	FARCT	CION						
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a		•									
	ate be executed physician and the burial-transit	al Exa	that initiated events resulting in death) Last	Due to (or as a				_							
200	cate be physic s the bu	edical		d				-							
. Box 687	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.  Funeral Director, After this certificate has been signed by the attending physician and Funeral Director, Pater this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth: 4 Pregnant at 9 Unknown	2 🗀 Feta	al death 3 🗌	Ectopic p Other (sp		,			2	3d. Date of del Month	ivery Day Year	
P.O.	es that the signed by t be detack		Part II. Other significant conditions co	intributing to death bu	it not res	ulting in the u	nderlying (	ause give	en in Part I		23e. Did to	obacco us	e contribute to	the cause of death?	
rds,	requires been sig should b	eted	END STAGE REI	NAL FAILUR	E						1 🗆	Yes 2		robably 4 🏌 Unknown	
Division of Vital Records,	The law n cate has b page 2 sh	Completed by									24a. Was autop perfo	osy ormed?	prior to death?	topsy findings available completion of cause of	
ital	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				26. Pla	ce of Deat	h (Check	only one)		· · · · · · · · · · · · · · · · · · ·		
of V	Phys r this eral dir	e: 10	1 ☐ Yes 2 ☒ No	1 X Inpatie 28a. Date of injur	y	ER/Outpatien 28b. Time of		Bc. Injury	4 ∐ Nu		ne 5 Resid		Other (Spec	ify)	
ono	ending I eath. or: After he funer	ficat	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation		Year)	injury	м	work?	es 2 🗆	- [	od. Describe r	iow injury	occurred		
Divisi	To the Hospital or Attend within 24 hours after death To the Funeral Director; completed filled in by the	al Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju- building, etc.	y - At ho (Specify	me, farm, stre )	et, factory	, office		2	28f. Location (S City or Tow		Number or Rui	ral Route Number,	
	e Hosp 24 hot e Funet leted fil	Medical	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin 3 Certifying Nurs	<b>1er:</b> On the basis of ex	aminatior	and/or investi	gation, in r	ny opinion	, death occ	curred at t	the time, date a	ind place, a	and due to the	cause(s) and manner stated.	
	To the vithin 2 To the comple	2	29b. Signature and title of certifier	e gracuoner; lo the t	osi UI IN)	knowledge, d	T	License		anu piace			and manner as signed (Month		
0			1 8%	NEGASH	Ay	ELE		D558	56			OCI	OBER 1	2, 2010	
R	2		30. Name and address of person who con Negash Ayele M		,	, , , , ,	,	ad S	ilver	Spr	ing.Ma	rvlar	nd 2091	0	
	Stat Registra		31. Date filed (Month, Day, Year)  OCT 1 5 2010	32. Registra	's Signat										

DHMH 17 Rev 7/2009

Please Type of Print in Black Indelible Ink/ Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month t 0640 Hancock Evans Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death S AUSOUL HOMICE 8. Date of Birth (Month, Day, Yea 9-29-1936 If Under 1 Year If Under 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) 1 🕅 M 2 🗆 F Months Days Hours Min. Country) Mary Land Yrs. **Director** 218-34-9277 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🙀 No Salisbury MD Wicomico 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral USA 810 Parker Road 21804 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes, Give Year or Dates White Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Sales Representative Nabisco Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Hancock Hilda Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Hancock - Wife 810 Parker Road, Salisbury, Maryland 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Crematory of Delmarva 10-13-2010 Delmar, Delaware 22. Name and Address of Facility Bounds Funeral Home E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or compli-shock, or heart failure. List only or dions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examine The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Prostate. Concu attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Director; After this certificate 2 🗌 No 1 Yes Division of Vital To the Hospital or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No 2' Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours To the Funeral Medical 29a. Certifier 1 Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 | Medical Examiner: On the basis of examination allows investigation, in the position of the basis of examination and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 10/09/2010

Registrar

DHMH 17 Rev 7/2009

State

SALISBURY Md. 21801

CARROLL ST.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

1008

Thomas Jay Ho		Please Type or Print in Black Indelible Ink. Ens State of Maryland / Department of Health Certificate of Death Registrar		Hygiene	gible. 2010 ag. No.	33922		
Physicia	an/	Decedent's Name (First, Middle,Last)		2. Date of Deat Month		3. Time of Death		
Medical Exami	ner	Thomas Jay Hoard, Jr.  4a. Facility Name (if not institution, give street and number)  Washington County Hospital  4b. City, Tow Hagerst	n, or Location of De		October 15, 2010 1528 hrs  4c. County of Death  Washington			
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1	Year If Under 24	N Sim	th(MM/DD/YYYY) 9. Bird 10,1966 Co			
eath with the Maryland items 23a or 28a-f show any ust be notified at once.	Director	10a. State 10b. County 10c. City, Town or Location  Maryland Washington Hagers  10e. Street and Number 10f. Zip Co		10	Og. Citizen of What Cour $U ullet S ullet A ullet$	10d. Inside City Limits 1 Yes 2 No		
MD 21215-0036 A 2 should be filed within 72 hours after death with the Maryland thin and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f showmatic event, the Medical Examiner must be notified at once.	by Funeral D	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year or Dates:  12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 1 Yes, Give Year or Dates:  13. Was Decedent or U.S. If Yes, specify C	of Hispanic Origin? ( uban, Mexican, Pue No <i>specify</i> :	erto Rican, etc.)	14. Race - Ameri White, etc.	can Indian, Black,		
11215-0036 Id be filed within 72 hours fontal Hygiene. 12rked other than "natur event, the Medical Exam	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  12  Technic.	g life. DO NOT use	retired)	16b. Kind of Business/I	,		
215-C e filed v al Hygi ced oth nt, the	Be Co	17. Father's Name (First, Middle, Last)  Thomas Jay Hoard, Sr.		ame (First, Middle, N ie Arlene	,			
MD 212 12 should b th and Meni 27 is mark	To E	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Stather)  19b. Mailing Address (Stather)  19c. Mailing Address (Stather)				Zip Code)		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within Uppartment of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposition (Name of crematory or other place)  Smithsburg Crematory	0	Date ctober 8, 2010	20c. Location - City or Smithsburg	Town, State g, Maryland		
		21. Signature of Funeral Service Licensee MO 1414 22. Name and Add	dress of Facility adbury Av	J.L. Day re. Smiths	vis Funeral sburg, Mary			
Physician Wedicar Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of defailure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	/ing, such as cardia	ac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death		
		Sequentially list conditions, b						
ii d	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disaass or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):						
e executed sian and ial - transit	ical	d.  ✓ AMENDED 1 as noted, 23a,27,2	28a-f per	me g913	3-25-11 vt			
Box 68760, e death certificate be exe the attending physician g ed for use as the burial—	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Specify)	3 Ectopic pres		23d. Date of delivery	l Jay Year		
P.O. I es that the signed by the detache	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cau	use given in Part I.		bacco use contribute to	_		
Division of Vital Records, P.O. B Univision of Vital Records, P.O. B vithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Completed				sy prior to c	topsy findings available ompletion of cause of s 2 No		
Vital Rec hysician: The I this certificate I	o Be	25. Was case referred to medical examiner?  1 Very 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other Nur		Residence 6 Other			
on of canding Pheath.	tion: To	27. Manner of Death  28a. Date of Injury (Month, Day, Year)  1 Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  1 1 1 1 1 1 2 1 0	Injury at Work? Yes 2 X No	28d. Describe h	ow injury occurred			
Divisi pital or Att ours after de eral Direct	ertification:	3 Suicide 4 Homicide  6 X Could not be determined  Could not be determined  (Specify)  Private dwelling	ice building, etc.	28f. Location (S	treet and Number or Ru	ral Route Number, City Cust St.		
Divisior  To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinand manner stated.						
	Ž		.C.M.E.		29d. Date signed (Mor October 16, 2010			
		30. Name and address of person who completed cause of death (Item 23a)  Margarita Korell MD. Assistant Medical Examiner 111 Penn Street	t, Baltimore, M	D 21201				
St Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October George D. Janis 17:10 2010 Medical 4a. Facility Name (if not institution, give street and number)
Heritage Harbour Health & Rehab. Center Examiner 4b. City, Town, or Location of Death Annapolis 4c. County of Death Anne Arundel Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) Virginia 140-09-8197 1**X** M 2 □ F Davs Hours 12/29/1918 **Director** Usual Residence of Decedent or 28a-f shov or than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 10b County within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director Maryland Howard Columbia 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21044 United States 10205 Wincopin Circle, Apt. 101 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, was Decedent Ever in U.S. Armed Forces? 1X Yes 2 No If Yes, Give Year or Dates. 1940-45 Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' United States Elementary Seconday (0-12) College (1-4 or 5+) Clerk Post Office other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bessie Bounelis James Gianacopoulos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip Janis/Son 10205 Wincopin Circle, Apt. 101, Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ö 1 A Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once, Maryland Veterans Cemetery: 10/13/2010 Crownsville, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature Males 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician, Lac Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Year Day ☐ Pregnant at time of death☐ Unknown Vas 2 No g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy death? After this certificate | 1 Yes 2 No Yes Hospital or Attending Physician: ] 24 hours after death. Funeral Director: After this certifica Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital: 2V No Other: ဂ္ 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? Natural iniury 5 Pending ☐ Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) filled in I 24 hours 29a. Certifier Cerpli(ying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title o 29c. License number 29d. Date signed (Month. Dav. Year) 20

Registrar
DHMH 17 Rev 7/2009

son who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 12, 2010 Physician/ 18:20 P Mary I. Joyner Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Southern Maryland Hospital Clinton 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months Days Hours Min. Dec. 24 Year 1924 North Carolina Director 578-34-9714 85 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director Marlo Heights 1 X Yes 2 No Prince George's Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20746 3940 Bexley Place hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🖾 No Specify: Black. If Yes, Give Year or Dates 3 → Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than " Elementary/Seconday (0-12) 12th College (1-4 or 5+) Private Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James White Mattie Nora Dupree 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Reginald King - Son 7515 Healy Place 20772 Upper Marlboro, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State October 22 1 🔀 Burial 2 🗌 Cremation 3 🗎 Removal from State 4 Donation 5 Other (Specify) 2010 Triangle, Virginia Quantico 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home, 4001 Benning Road NE 20019 Washington, DC 23a. Part Letter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Onset and Death Immediate Cause (Final Trenesclero tic Physician/ Cardio Vasa disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): physician and the burial-transit that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ρ Month Day Year Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has performed 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 10 Hospital: ဂ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 1 Natural 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending s after death. I Director: Aft 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be in by 1 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a filled Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотріете 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within To the 29b. Signature and title of certifier m Side

State Registrar

Maryland 21215-0036

Box 68760

Records,

Division of Vital

M.D 1/10/ 32. Regist ar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sidanons

livingstan ad #101 ftc Ar yla MA 20764

State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ 10:50 A M October 5, Leonard Johannas Karhu Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 904 Marble Court Wicomico Salisbur 5. Social Security Number If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 X M 2 - F Months 0ays Hours Ohio 93 09/15 1917 Director 298-10-4473 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Examiner must be notified at **Funeral Director** 1 X Yes 2 No Salisbury Maryland Wicomico ò 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? or items 23a 21804 USA 904 Marble Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No US If Yes, Give Army Air Year or Dates CORDS Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White "natural", 3 Widowed 4 Divorced other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) IRS-Federal Government Field Auditor 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jack Karhu Ida Keskimaki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 904 Marble Court, Sailsbury, Maryland 21804 Mildred Karhu-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 10|08|2010 Salisbury, Maryland Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses PA Name and Address of Facility Home PA 501 Snow Hill Rd., Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ 6 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ASCVI) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the attending physician and hed for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown page 2 should be detached 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 2 No 1 Yes Yes director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify, 1 Tes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 47094 10/8/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUISBURY NATELIN 5-DIVISION STULL 1415 vel 31. Date filed (Month, Day, Year) ♪ 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene [ ] Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 09 Physician/ 2010 Wendell E. Lilly, Sr. 03:18 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Annapolis Examiner 4c. County of Death Anne Arundel Anne Arundel Medical Center 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min 233-30-7729 1 □XM 2 □ F 85 Months Hours 0270871925 West Virginia Director Usual Residence of Decedent show or 28a-f shov notified at 10a. State within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Anne Arundel 1 Yes 2 No Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a o 21403 Funeral 2707 Ogleton Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Completed White WW II Year or Dates. event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Home Construction Builder Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Okey Lilly Macie Richmond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2707 Ogleton Road, Annapolis, Maryland 21403 Marie P. Lilly/Wife other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 s Department of H Important: If ite any injury or otl once. Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Lakemont Memorial Gardens 10/15/2010 4 Donation 5 Other (Specify) Davidsonville, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Stroke disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): the burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Year Day Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 1 Yes 2 No Yes 2 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 No 욘 1 XInpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After (Month, Day, Year) Natural 5 Pending 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined Medical 29a. Certifier 🌠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier peix Bech, My 29d. Date signed (Month, Day, Year) D46052 10/09/10 20 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 Medical Parkway amapolis, No Sjourd Beil, HO 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 9 2010 Year OCTOBER JAMES Η. LOCKETT 8:39 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S PRINCE GEORGE'S CHEVERLY . Social Security Number 8. Date of Birth (Month, Day NOV • 26 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday) Hours 1 \ X M 2 □ F WASHINGTON, DC Director 1946 578-66-3240 63 Yrs Usual Residence of Decedent 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked other than "natural", or items 23a or 28a-f sho amportant: In item 25 is marked other than "natural", or items 25 is notified at a more injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 √ Yes 2 □ No MD PRINCE GEORGE'S BRENTWOOD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4018 PARKWOOD COURT 20722 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 X Married 2 No 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10тн PHARMACY TECHNICIAN PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ BROWN JAMES LOCKETT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHRISTINE C. LOCKETT/WIFE 4018 PARKWOOD COURT BRENTWOOD, MARYLAND 20722 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other placel 1 Burial 2 X Cremation 3 Reg 4 Donation 5 Other (Specify) RIVERDALE CREMATORY 10-13-2010 RIVERDALE, MARYLAND Signate of Funeral Sept ce Licensee J. B. JENKINS FUNERAL HOME, INC. 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each are. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) Pregnant at time of death Yes 2 No q | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Tes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 2 🖾 No 1 Tes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 1 🔲 Yes 2 Certificate: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of injury (Month, Day, Year) 27. Manyler of Death 28b. Time of e Hospital or Attending P 124 hours after death. e Funeral Director: After t leted filled in by the funera 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature a 29c. License number

State Registrar 31. Date filed (Month, Day, Year,

of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33928 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 11, 2010 Physician/ 14:24 PM <u>Patria</u> Dandy Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Clinton Prince George's Southern Maryland Hospital Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🏋 F (Month, Day, Year, ec. 21, Months Days Hours Min South Carolina Director Dec. .923 578-38-1922 86 Usual Residence of Decedent show ge 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. It flew B23 or 28a-f show It flew B27 is marked other than "natural", or items 23a or 28a-f show or of the fraumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Clinton Maryland | Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 6803 Summit Creek Drive 20735 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🗷 No Baltimore, Maryland 21215-0036 African American 1 ☐ Yes 2 A No Specify: If Yes, Give 3 Nidowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 8th College (1-4 or 5+) Homemaker Private Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charley Dandy Fannie Gennie Mathis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2059 36th Street SE Washington, DC Carrie L. Thornhill/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ot Date ober 16, cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Maryland Cedar Hill 21. Signature of Fune A Ser A e Licer 22. Name and Address of Facility Stewart Funeral Home, Benning Road NE Washington, DC 20019 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on mach line. Approximate Immediate Cause (Final Onset and Death di 14 (Physician) disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burlar-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed/?

1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 📝 No Other: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 7 Day 2010 ear 12:20 P M Ossie Mae Larry Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Southern Maryland Hospital Clinton 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🍱 F Months Hours June 11, 1926 South Carolina Director 84 250-54-2042 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Suitland 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20746 United States 4188 Suitland Road # 401 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 **Black** 1 Yes 2 No Specify If Yes, Give Year or Dates 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private Homemaker 6th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Pickney Bradford, Sr. Fannie Peterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valerie Bradford/ Daughter 4188 Suitland Rd. # 401 Suitland, Maryland 20746 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place October 15, 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Suitland, Maryland 21. Signature a Funeral Service 122. Name and Address of Facility Stewart Funeral Home, Inc. 10 com 001 Benning Road NE Washington, DC 23a. Part 1. Enter the diseas a on complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List inly one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ myo cardin Medical resulting in death) Examiner ongestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or linjury that initiated events resulting in death) Last Acule 011 Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Month Pregnant at time of death g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No Yes eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🛛 No Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No hours after death Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a To the Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type,

D0065720

10/13/2010

			For State Registrar	State of M		epartment of F Certificate of L		and Me		giene Reg. No. 0	10	33930
	Physicia	n/	1. Decedent's Name (First, Middle	, Last)					2. Date of De		Voor	3. Time of Death
	Medic	al	Richard La						Month.	29	20/0	1948 PM
	Examin	er	4a. Facility Name (if not institution,	. / .	contes	4b. City, Town, or	Location 1/1564			4c. Cour	nty of Death	ria
	Funeral		5. Social Security Number	6. Sex ( 7. Age	e (In yrs. last birtho	fay) If Under 1 Year	If Unde	r 24 Hrs. 8	8. Date of Bir	th	9. Birthp	lace (State or Foreign
	Director		222-24-1434	1 🗶 M 2 🗆 F	_76 Y	rs. Months Days	Hours	Min.	(Month, Da	y, Year) <b>34</b>	Dela	nware
pur	show	٥	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town of	or Location					1	0d. Inside City Limits
Maryla	8a-f	rect	DE Suss	sex	Laurel							1 🗆 Yes 2 🗓 No
h the	a or be no	Funeral Director	10e. Street and Number			10f. Zip Code				10g. Citizen o	of What Coun	try?
th wit	ms 23	ner	27791 Layton Ro			199			i	US	<u>A</u>	
o er dea	or ite		<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ▼ Marr</li></ul>	12. Was Decedent E Armed Forces? 1 \(\sum \) Yes 2 \(\foldax\)		<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>	ispanic Or ın, Mexica	rigin? (Specit an, Puerto Ri	fy Yes or No- can, etc.)		ace - Americ lack, White, e	
JOS urs aft	urat", i Exar	ed k	3 Widowed 4 Divorced	If Ven Chie		1 ☐ Yes 2 ☐ XNo	Specify	<i>/</i> :		Speci	ify: Whi	te
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<b>21215-0036</b> within 72 hours after	r thar	Con	Elementary/Seconday (0-12)	College (1-4 or 5	i+) //	fe. DO NOT use retired)				Con a di	/D T	
iled v	al Hyg i othe vent,	Be	17. Father's Name (First, Middle, L			Farmer				Maiden Surna	n/Poul <sub>me)</sub>	ry
ylar Id be	Menta arked atic e	욘	William Layton	1			Flo	orence	Baile	y		
Maryland 2 should be filed	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationsh	nip (Type, Print)		Mailing Address (Street						code)
and and	Healt tem 2 other		Alice Layton 20a. Method of Disposition	(Wife)		791 Layton Disposition (Name of	Road	Laure		20c. Location		State
mo	nt: If i		1 Burial 2 Cremation 4 Donation 5 Other (S		cemetery,	crematory or other place			, 2010		•	
<b>Saltimore,</b> permit. Page 1 and	porta porta y inju		21. Signature of Funeral Service L		Toda res	22. Name and Addres			, 2014	Laui	er, De	laware 19956
<b>n</b> 8		1. 1	Holly Short			Hannigan,S					W.St.	Laurel,De.
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X 000	r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy	3 Ectopic pregnanc	2/			23d. [	Date of delive	ry
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that the	ed by t detact	/ Ph	Part II. Other significant conditio	ns contributing to death be	ut not resulting in	the underlying cause give	ren in Part	: I.	23e. Did to	nhacco use co	ntribute to th	e cause of death?
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Phys	r this c	٠ <u>۲</u>	1 Yes 2 No	1 Inpatie	ent 2 ER/Outp		4 ∐ N			ience 6 🗆 Ot		
onding	ath. r; After e fune	icate	1 X Natural 5 ☐ Pending 2 ☐ Accident Investig	g (Month, Day		iry work			a. Describe n	ow injury occu	rred	
DIVISION OF	rector	Certificate:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	not be		, street, factory, office		28			ber or Rural	Route Number,
	urs aff rral Di								City or Tow			
Hosp	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 L Medical Ex	Physician: To the best of examiner: On the basis of ex	camination and/or in	nvestigation, in my opinio	n. death o	ccurred at the	e time, date a	nd place, and c	tue to the cau	se(s) and manner stated
To the	within	Σ	29b. Signature and title of certifier	Nurse Practioner To the		29c. License	number	,		29d. Date sign	ed (Month, E	Dav. Year)
<b>D</b> 1	,		bon	M.D.		D39	204	1		Sept.	29,	2010
	Su		30. Name and address of person w	who completed cause of de	eath (Item 23a) (Typ	D39  De, Print)  D E. Car	ro11	1 st.	Sales	bur	MD	21801
	Stat Registra	e Ir	31. Date filed (Month, Day, Year)	100	r's Signature	barks						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-07817 State of Maryland / Department of Health and Mental Hygiene John Paul Landry, Jr. Certificate of Death 1. For State Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month 1724 hrs October 11, 2010 **Medical Examiner** John Paul Landry, Jr. c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Southern Maryland Hospital Clinton If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** country) Germany Months Days Hours Director 1960 219 72 5013 Jan 1. 1 X M 50 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 No or 28a-f show MD P.G. Temple Hills notified at once. death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5108 Sharon Road United States 14 Race - American Indian, Black 13. Was Decedent of Hispanic Origin? (Specify Yes or No Funeral 12. Was Decedent Ever in U.S. 11. Marital Status 27 is marked other than "natural", or items umatic event, the Medical Examiner must be White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 X Married Bi-racial 1 X Yes Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after c
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or
injury or other traumatic event, the Medical Examiner m 1 Yes 2XX No specify: Specify: Black/White If Yes. Give Year 4 Divorced ੬ 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Dog Training 12 Self Employed 18.Mcther's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rosemarie Pfiefer John Paul Landry, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5108 Sharon Road, Temple Hills, MD 20748 Gina Landry (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Lee Crematory Oct 13, 2010 Clinton, Maryland 4 Donation 5 Other Specify: 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Sun after of Funeral service Licensee Ferry Road, Clinton, MD 20735 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Retween Onset and failure. List only one cause on each line Death M-dical Dilated cardiomyopathy Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and - transit certificate be executed Physician/Medical AMENDED a, 27 per ME g909 11/30/10 TT X UNPENDED attending physician or use as the burial -Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an certificate has been sector page 2 should prior to completion of cause of autopsy death? performed? Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi 25. Was case referred to medical Be Division of Vital Other Nursing Home 5 Residence 6 Other 1 🗸 Yes 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 1 X Natural 1 Yes 2 No Pending Director: d in by the f Investigation 2 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

Donna M. Vincenti, MD 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

OCME

29b. Signature and title of certifier

32. Registrar's Signatur

Assistant Medical Examiner

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

October 12, 2010

10-07557	
John Lahman	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

John Lamman		1- For State Certificate of Death Registrar		/giene Reg.	2010 No.	33933
Physici Medical Exam		Decedent's Name (First, Middle,Last)		2. Date of Death Month D October 1, 2	)ay Year	3. Time of Death 1753 hrs
Wiedical Exam	ilei	OOM WIBBIAN BANKAN	wn, or Location of Death	October 1, 2	4c. County of Death	
		WMR MC Cumbe		<b>1</b>	Allegany	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 218-62-6204 1 Nm 2 F 58 Yrs. Usual Residence of Decedent	1 Year If Under 24Hrs.  Days Hours Min.	12/31/1	MM/DD/YYYY) 9. Bird Foreig Col	
any		10a. State 10b. County 10c. City, Town or Location	<del></del>			10d. Inside City Limits
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be polified at once.	Funeral		of Hispanic Origin? (Spe Cuban, Mexican, Puerto F		White, etc.	can Indian, Black,
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MD 2 td 2 shoul tlth and M m 27 is m	٩		(Street and Number or Ri DWAY, FROST			Zip Gode)
Baltimore, Nemir Pages I and Department of Healti Important: If item injury or other trau		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  CUMBERLAND CREM		Date 2	Oc. Location - City or CUMBERL	
altin mit. P spartme iportan jury or	ł	21. Signature of Funeral Service Licensee 22. Name and Ad			JNERAL HOM	
m ឧក្ខុធ្ន Physician		23a. Par I /Enter the disease, or complications that caused the death. Do not enter the mode of d	REENE STREET	CUMBER	RLAND, MD	21502 Approximate Interval
/Medical Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):				Between Onset and Death
		Sequentially list conditions, b				
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6876 ertifica ding ph		23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death	3 Ectopic pregnan		Month D	ay Year
Box death c he atten d for us	Physician/	1 Yes 2 No 9 Unknown 9 Unknown Other (Specify,	)			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	2	Part II. Other significant conditions contributing to death but not resulting in the underlying ca	use given in Part I.	1 —	cco use contribute to the 2 No 3 Proba	
Division of Vital Records, tal or attending Physician: The law requin rs after death.  al Director: After this certificate has been siled in by the funeral director, page 2 should b	Completed			24a. Was an autopsy	prior to co	opsy findings available impletion of cause of
Reco	E O			performe 1 Yes 2		2 No
Vital Rec ysician: The I his certificate I	a	examiner? Hospital: 4 Innation 2 4 EB/Outpetient 3 DOA	Place of Death (Check or Other'4 Nursing		sidence 6 Other:	
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Sion Attendii death. ctor: A	atio	Natural 5 Pending 10/1/10 Fd 16: 48 1			-	
Division of V To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	Certification	3 Suicide 6 Could not be determined (Specify) residence	ice building, etc. 2	28f. Location (Stree or Town, State Frostbur	et and Number or Run 9911 Broad 3, MD	al Route Number, City way St
Fo the Ho: within 24 P Fo the Fu	edical	29a. Certifier 1 Check only one)  2 Medical Examiner: On the best of my knowledge, death occurred at the time one)  2 Medical Examiner: On the basis of examination and/or investigation, in my open and manner stated.	pinion, death occurred at	the time, date and	place, and due to the	cause(s)
	Σĺ		o.C.M.E.		October 3, 2010	h, Day,Year)
		30. Name and address of person who completed cause of death (Item 23a)  Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Bal	Itimore, MD 21201	•		
	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature			<u> </u>	
Regist	rar	OCT 28 2010 Janua S. Jak				

DHMH 17 Rev 1/2001 OCME 2006

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October DiB 6:10 A. M. CORGE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BWMC BURNI EN 4nne A MUNDEL 8. Date of Birth
(Month, Day, Ye If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🏻 M 2 🗆 F Months Hours Min. Pennsylvania 90 220-01-6013 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Severna Park 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 101 St. Andrews Road 21146 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No WWII
If Yes, Give Black, White, etc. 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Cartographer Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Clark Edgar Myers Sara Werner 19a. Informant's Name/Relationship (Type, Print)

Daughter-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 St. Andrews Road Severna Park, MD 21146 Lettie A. Myers in-law 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State October Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, INC 2010 21. Signature of Language Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home Severna Park, MD 21146 495 Ritchie Hwy. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart latiture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine If any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Pregnant at time of death 1 Yes 2 9 Unknown 2 🔲 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 2 **N**O 3 Probably 4 Unknown Completed 1 Yes After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 npatient 2 ER/Outpatient 3 DOA 1 Natural 2 Accid Director: After this in by the funeral 28a. Daje of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 5 Pending 2 No Investigation Could not be Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours at To the Funeral Dicompleted filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29b. Signature and title of certifier Name and addr person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Regist

13

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

imothy L. Moore		I- For State	tate of Maryla		artment of		nd Mer	ntal Hy	_	201	0	33935		
Physician Medical Examine	1/	1. Decedent's Name (First, Midd	, ,						2. Date of Dea	Day Year		3. Time of Death 0515 hrs		
ngaroar zxamin		Timothy Ty  4a. Facility Name (if not institution	on, give street and nu	mber)		4b. City, Town, o	r Location	of Death	October 1	4c. County of	f Death			
		Peninsula Regional M	Medical Center			Salisbury				Wicomic	0			
Funeral Director		5. Social Security Number		7. Age (In yrs.	•	If Under 1 Yes		ler 24Hrs.	1	irth(MM/DD/YYYY)	9. Birth Foreign			
Director	ŀ	216-70-6847 Usual Residence of Decedent	1 X M 2 F		50 Yrs				July 3	30, 1960	Cou	ntry) MD		
kus	-	10a. State 10b. County		10c. City	, Town or Locati	on						10d. Inside City Limits		
and show	5	MD Wi	.comico	1	Delmar							1 Yes 2 X No		
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21215-0036 21215-0036 wild be filed within 72 hour Mental Hygiene. marked other than "natue event, the Medical Exam To Be Commisted	┋┞	17. Father's Name (First, Middle	, Last)		Consti	ruction	18.Mothe	r's Name (	First, Middle,	Maiden Surname)	ciai	Building		
21215-00 build be filed wind the marked other in marked other ic event, the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month of the Month o	ם מ	C.T. Moore					Ва	arbar	a Buck	1e				
O 5 5 5 5 1	2 [	19a. Informant's Name/Relations	ship (Type, Print )		19b. Mailing	Address (Stre	et and Nur	nber or Ru	ıral Route Nu	mber, City or Town	, State, 2	Zip Code)		
re, MD 2 shou f Health and I li item 27 is ner traumatic	-	C.T. Moore ( 20a Method of Disposition	Father)	20b.		Memor			De Date	1mar, MD				
F E E		1 X Burial 2 Cremation	-	om State	crematory or oth	er place)	A=11**							
Baltimo permit. Page Department Important: injury or otl		4 Donation 5 Other S  21. Signature of Funeral Service	Donation 5 Other Specify: St. Stephens Cemetery 10-19-2010 Delmar, De Signature of Funeral Service Licensee  22. Name and Address of Facility Short Funeral Home											
Balt permit. Depart Import injury		Amer Short	Delmar, I	DΕ	19940									
Physician	1	<ol> <li>Part I. Enter the disease, or failure. List only one cause</li> </ol>	on each line.			e mode of dying	, such as c	cardiac or	respiratory an	rest, shock, or hear	rt	Approximate Interval Between Onset and		
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a			ardiova	scula	r di	sease			Death		
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Box 68760, to death certificate be enthe attending physician and for use as the burial red for use as the burial physician/Medician/Medician/Medician/Medician/Medician/Medician/Medician/Medician/Medician/Medician/Medici	2	F FEMALE: 3b. Was decedent pregnant in the past 12 months?	23c. If yes, o	outcome of preg	inancy	al death 3		c pregnan	су	23d. Date of d Month	lelivery Da	ıy Year		
Sox 6 leath cer e attendi for use	200		ten aven   '	ant at time of de	eath 5 Oth	ner (Specify)								
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Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been si led in by the funeral director, page 2 should bertification: To Be Completed			stigation 28e. Place	of Injury - At he	ome, farm, stree	t, factory, office t	ouilding, et	tc. 2			or Rura	I Route Number, City		
Division o spiral or Attending tours after death.  The filled in by the function:  Certification:		4 Homicide dete	rmined (Specify)						or Town, S	State)				
3 - 3 >	1 2		hysician: To the best iminer:On the basis o											
To the Howithin 24 To the For To the For completed		29b. Signature and title of certifie	and manner st	ated.		29c. Licens			date	29d. Date signed				
		Monage D	n. Ul. 11			O.C.				October 16,		, , , ,		
	3	30. Name and address of person	who completed cause	e of death (Item	1 23a)									
		Margarita Korell MD.	Assistant Med			enn Street, B	altimore	e, MD 21	1201					
State Registra	~	31. Date filed (Month, Day, Year)	2010 32.5	gistrar's Signatu	B. Sar	Ked								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day Virginia Helen Mull tober 10,2010 0530 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salisbury Rehabilitation + Nursing Ctr licamico lisbo Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** 1 □ M 2 🔀 F Days Hours Months Min 251-46-2650 78 **Director** 11/19/1931 South Carolina Usual Residence of Decedent should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Item Modical Experience must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Wicomico Hebron 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26299 Rewastico Road 21830 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify δ Specify: 3 XWidowed 4 Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) data auditor Westinghouse Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Jesse Hipp Edna Louise Hannon ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edna E. Young/daughter 7732 Quantico Rd., Hebron, MD 21830 ltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Springhill Memory 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/13/2010 Hebron, MD Gardens Service Licensee Holfoway Fureral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Composer CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** /Medical resulting in death) Due to (or as a consequence of); Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician end for use as the burial-tran-Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 Other (specify) by the a ☐Yes 2 No g Unknown 9 Unknown signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate has ral director, page 2 s 24a. Was an 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Director: After the in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 □ No 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide A 24 hours the Funeral Dire 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) vic Ave. Solisbury MD egistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2010 October 0 18 РМ Barbara Jane Malin 2200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ceci1 251 Ed Moore Road E1kton If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, AUG 30, 9. Birthplace (State or Foreign **Funeral** Days Min. Months Hours 1 □ M 2 🔀 F Delaware 81 222-16-5002 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show d other than "natural", or items 23a or 28a-f showevent, the Medical Examiner must be motified at 1 ☐ Yes 2 No Director E1kton Maryland Cecil 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 251 Ed Moore Road 21921 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🛣 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Modical Examination once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: þ If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Nursing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be J. Harvey Moore Sarah Elizabeth Hathaway ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 251 Ed Moore Road, Elkton, MD 21921 Jesse Malin/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) October 23 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2010 4 ☐ Donation 5 ☐ Other (Specify) Sharps Cemetery Fair Hill, MD 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 21921 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a conseq nce of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 

Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the inector, page 2 s autopsy performe 1 □Yes 2 ☑No o 24 hours after death.

Funeral Director: After this certific letely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Hosp within 24 ho To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certife 29c. License number ho completed cause of death (Item 23a) (Type, Print) tigh ST, Elha MD21921. SACHDEN MO 32. Registrar's Signature State Registrar

		For State	Fie	ase Type or State o		nd / Dep	artment of rtificate of	Health			/gien	e	ne.	33938
Physicia	an/	1. Decedent's Name	e (First, Middl	e, Last)	7FIC		timeate of	Douth		2. Date of D Month	D	)ay	Year	3. Time of Death
Medic Examir				n, give street and num Nursing H	nber)	/	4b. City, Town,		of Death	l Octob	T .	1, 20 c. County o	f Death	12:10P M
Funeral Director		5. Social Security N 559-50-6	umber 207	6. Sex 1 \( \text{M} \) 2 \( \frac{1}{2} \frac{1}{2} \)		. last birthday) Yrs.	If Under 1 Year Months Day	r If Under	24 Hrs. Min.	8. Date of Bi (Month, D Mar 2	irth lay, Yea <i>r</i> )			place (State or Foreign
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by		15. Decede	Year or Da ent's Education est grade completed)  College (1-		(Give	dent's Usual Occi kind of work done IO NOT use retire	e during mos d)	t of work	king	De	Kind of Bus fense Insti	iness Ind	dustry nguage
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age 1 and ent of Heal nt; If item ry or other		20a. Method of Disp	position  Cremation	3 ☐ Removal from	State	Place of Dispo cemetery, crei	psition (Name of matory or other pi	ace)		Date	20c. l	Location - C	ity or To	
Physician/ Medical Examiner	Examiner	23a. Pivil. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.    Immediate Cause (Final disease or condition resulting in death)   Marking and Address of Facility Going Home Cremation Service P.O. Box 784												
death certificate be te attending physici ed for use as the bu	/Medical	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 5 9 ☐ Unknown	pregnant months? X️No	d	come of pregr Birth 2  Fe nant at time of own	nancy tal death 3 [ f death 5 [	Ectopic pregna					23d. Date Mont		ery Day Year
requires that been signed should be det		Part II. Other signif	icant condition	ons contributing to de	eath but not re	esulting in the u	inderlying cause	given in Part	l, 					e cause of death?
: The law re icate has be ; page 2 sh	Completed by					4-4				24a. Was auto perf 1  Yes	opsy ormed?	pri de	or to cor ath?	osy findings available mpletion of cause of
To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director, After this certificate has been signed by it completed filled in by the funeral director, page 2 should be detached.	cate: To Be	25. Was case referred examiner?  1  Yes 2 2  27. Manner of Death  1  Natural  2  Accident	<b>X</b> No	28a. Date of (Mont		ER/Outpatier 28b. Time of injury	nt 3 DOA		ursing Ho	k only one) ome 5 $\square$ Res 28d. Describe			(Specify)	)
To the Hospital or Attending Phyilin 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	al Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	not be 28e. Place	of Injury - At h ng, etc. (Speci	nome, farm, str	eet, factory, office			28f. Location ( City or To			or Rural	Route Number,
the Hospi hin 24 hou the Funer npleted fill	Medical	(Check 2 only one) 3	☐ Medical E	Nurse Practioner:	s of examination	on and/or inves	tigation, in my opio death occurred at	nion, death oc the time, date	curred a	t the time, date	and plac he cause	e, and due to (s) and manr	o the cau ner as sta	use(s) and manner stated ated.
or with		29b. Signature and	title of certifier	Rukre	to			se number 005207	5			ate signed (i ctober		Day, Year)
Star Registra		Deep K	, Kukreti	32. Re		nington	Print)  Blvd. S  backs	uite I	, La	aurel,	Mary	land	2072	23

DHMH 17 Rev 7/2009

PI	ease Type or P					-		gible.
For State	State of N	/laryland / De	epartment of Certificate of		and Me	ental Hygle	ene	
Registrar  1. Decedent's Name (First, Mi	iddle Last)		ertificate of	Death		2. Date of Death	Nay 1	10 13.3.9.3.9
George	Ogilvie					Month  OCTOREA	Day 2	Year 2010 1: 00 A M
a. Facility Name (if not institu		1	4b. City, Town	, or Location		DUISBER	4c. County	
FutureCare			Arn					Arundel
. Social Security Number 176–12–6558	1 🗶 M 2 🗆 F	nge (In yrs. last birthda 89 Yrs	Months Day		Min.	8. Date of Birth (Month, Day, Ye Sep. 13,	<sup>ar)</sup> 1921	9. Birthplace (State or Foreign Country) Pennsylvania
Jsual Residence of Decedent  0a. State 10b. Cou		10c. City, Town or	r Location					10d. Inside City Limits
MD An	ne Arundel		erna Park					1 ☐ Yes 2 🔀 No
0e. Street and Number 42 Marnel Co	urt		10f. Zip Cod	21146		10g		What Country? USA
1. Marital Status  1 Never Married 2  3 Widowed 4 Divor	If Vec Give	?	13. Was Decedent of If Yes, specify Co	uban, Mexica	n, Puerto Ri	ify Yes <i>o</i> r No- ican, etc.)		e - American Indian, ck, White, etc. :: White
(Specify only h	edent's Education ighest grade completed)	(G	ecedent's Usual Occ ive kind of work dor e. DO NOT use retire	e during mos	st of working	16	b. Kind of B	usiness Industry
Elementary/Seconday (0-1 12	2) College (1-4 o	5+)	Dr	iver			Publ	ic Transit
7. Father's Name (First, Midd David M. Ogi					er's Name ( I <b>th Mu</b>	(First, Middle, Mai rphy	den Surnam	е)
9a. Informant's Name/Relati Margaret Ogi		19b. N 4	Mailing Address (Stre 2 Marnel	et and Numb Court	er or Rural I Seve	Route Number, Ci	ty or Town, S	State, Zip Code) 21146
0a. Method of Disposition  1 XBurial 2 Cremat 4 Donation 5 Oth	ion 3 XRemoval from Sta	te cemetery,	isposition (Name of crematory or other p yal Cemet	ery	Oct. Da 201	16,		- City or Town, State
21. Signature of Funeral Servi	ce Licensee		Barranco 495 Ritch	dress of Facility & Sons	b, P.A	A. Severi	na Par na Par	k Funeral Home k, MD 21146
23a. Part 1. Enter the disease shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death)	e, or complications that caus ist only one cause on each li a. Due to (or a	ne. EMENTI	enter the mode of d					Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	s a consequence of):						
Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or a	s a consequence of):						
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No		at time of death	3  Ectopic pregn 5 Other (specify)					ate of delivery onth Day Year
Part II. Other significant con	ditions contributing to death	but not resulting in the	he underlying cause	given in Part	l.	23e. Did tobac		ribute to the cause of death?  3  Probably 4  Unknown
						24a. Was an autopsy performe	d3/	Were autopsy findings available prior to completion of cause of death?
5. Was case referred to medi	cal		26	Place of Dea	ath (Check o		▲No	1  Yes 2  No
examiner?	Hospital:	atient 2 ER/Outpa	_ [	)ther:		ne 5 🗆 Residenc	e 6 \ Oth	er (Specify)
27. Manner of Death  1 Anatural 5 Pe 2 Accident Inv	28a. Date of in	jury 28b. Tim	e of 28c. In		28	3d. Describe how		-

sate has been signed by the attending physician and page 2 should be detached for use as the bunal-transit within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director,

Medical

Examiner

Medical Certificate: To Be Completed by Physician/Medical

2 Accident
3 Suicide
4 Homicide

6 Could not be

determined

Director

Funeral

Completed by

Be

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Physician/

Medical

**Examiner** 

Funeral Director

show

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D575 October 11, 2010 MY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 601 Moh 31. Date filed (Month, Day, Year) 0CT 13 2010 32. Registrar's Signature

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Year October 0 L. 12:33 A M Mona Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death South River Health & Rehab. Center Edgewater Anne Arundel If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 □ M 2 🖁 Hours Min 7/4/1923 West Virginia 234-30-9401 87 Director Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Marvland Anne Arundel Edgewater 10e. Street and Number 10g. Citizen of What Country? Funeral USA 144 Washington Rd. 21037 within 72 hours after death 12. Was Decedent Ever in U.S. Arnyed Forces? 1 ⚠ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White Completed 3 X Widowed 4 □ Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Systems Printing Executive U.S. Air Force Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be filed tment of Health and Mental H tant: If item 27 is marked ot Austin Bradshaw Nanny Lee Ball 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clifton M. Owens, Jr./Grandson 3550 Sage Meadow, San Antonio, TX 78222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MD Veterans Cemetery 10/14/2010 Crownsville, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ ereprovascular Accident Medical resulting in death) Examiner Atheroscienotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit Hecell Hypertensive Physician/Medical Box 68760 be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death 1 ☐ Yes ∠ y 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by melli tus Diobetes Records, 1 Yes 2 No 3 Probably 4 Unknown Hyperlipidemia 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 🗌 No Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 1 No Other: ျ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: e Hospital or Attending P 124 hours after death. e Funeral Director: After the leted filled in by the funeral 28d. Describe how injury occurred 1 Natural injury 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) yan 50653 ED 10-7-2010

Registrar
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32. Fegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10:05 2010 Evelyn Oberholtzer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Nicomico Salisbury Hospice If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral 1 M 2 X F Months Days Hours (Month, Day, Year) New Jersey Director 140-20-6521 85 Usual Residence of Decedent 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a -f show ther traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10d. Inside City Limits Director 1 🏋 Yes 2 □ No Salisbury Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 USA 707 Alvin Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black White etc. Completed by 1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Married 2 Married とくとしゅの Uberho I FZ ca Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: Specify: 3 ☑ Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Electronics Draftsman 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Clark Ruth Alice Franklin Eugene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1005 Bayshore Court, Salisbury, Maryland 21804 Department of Health Important: If item 27 any injury or other the once. Alice E. Cook - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-12-2010 Delmar, Delaware Crematory of Delmarva 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician CARDIOMYOPATHY disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Li retail deca.
Pregnant at time of death
Unknown 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Dav signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2) ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy page performe Yes 27 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) HOSPICAZ Hospital Other: ျ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred nours after death. neral Director; After the filled in by the funeral Certificate: Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the F within 2. 29b. Signature and Atla 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1300 WAR Haray

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day,

Day, Year)

3 1

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33942 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCT The LEONE ALICIA OLSEN 17, 2010 2:30A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 11345 BERRY ROAD WALDORF CHARLES Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Month, Day, Year) 12-8-1928 1 M 2 X F Months Days Hours Min. ALA . 419-30-8872 Director 81 Usual Residence of Decedent or 28a-f show se notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examinar must hamorismant. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD. CHARLES WALDORF 1 Yes X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11345 BERRY ROAD 20603 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 😾 No Specify: Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) N.O.S.-INDIAN HEAD Elementary/Seconday (0-12) College (1-4 or 5+) INVENTORY SPECIALIST U.S.GOVT. 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ CLYDE EUGENE CREGAR DOROTHY GRACE WEBER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM W. OLSEN-SPOUSE BERRY RD. 11345 WALDORF, MD. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) RIVERSIDE MEM.PARK 10-23-10 | JACKSONVILLE, FL. 21. Signature of Juneral Service Licensee Name and Address of Facility M00479 RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final o card Physician/ disease or condition **Medical** resulting in death) as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine (or as a consequence of) Cause (Disease or iinjury that initiated events prono attending physician and for use as the burial-trar Due to (or as a consequence resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Dav Year 5 Other (specify) the Unknown 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes\_2 **X**No certificate 1 Yes 2 No I 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 X No မှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Director; After this 27. Manner of Dea 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work?
1 Yes 2 No 5 Pending injury Investigation 6 Could not be ☐ Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide City or Town, State) within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗌 Certiffing Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29d. Date signed (Month, Day, Year) 2010 who completed cause of death (Item 23a) (Type, Print) State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 33943 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER 2 Cio 1050 AM John Francis PECK Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Washington Washington County Hospital Hagerstown 9. Birthplace (State or Foreign Country)
Wash. D.C. Social Security Number 6. Sex 1 ፟፟ M 2 ☐ F Age (In vrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Months Hours Min 75 Director 577-52-1901 Aug. Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits ms 23a or 28a-f s must be notified 1 X Yes 2 No Maryland Washington Hagerstown 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 702 E. Washington Street 21740 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. 0 δ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: "natural" Completed 3 Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 0 Salesman Auto Dealership Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ပ Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 15074 Glade Terrace, Greencastle, Pa. 17225 John Shadoan - Friend or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of F Important: If ite any injury or ot once, . Page 1 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 10/15/10 Hagerstown, Maryland Signature of Euneral Service Licer 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit Physician/Medical certificate be 68760 IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant 23d. Date of delivery Box Live Birth 2 Fetal deal
Pregnant at time of death Fetal death 3 Ectopic pregn 5 Other (specify) in the past 12 months? Month Day Year signed by the a 2 No g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Flecords, een sig 24b. Were autopsy findings available prior to completion of cause of 24a. Was an director, page 2 s certificate has autopsy performed death? Yes 2 No 2 🗆 Ño 1 Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? မ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 After this completed filled in by the funeral 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After work? 1 🗆 Yes 2 🗆 No Natural injury Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my income at the course of the time. Set and class and class and class to the news (s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year)

State Registrar

3H-6

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death, item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Thaddeus William Potocki 2010 October 4:33 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 836 Creek View Road Severna Park Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country)
Maryland 1 **X** M 2 □ F Days Hours 83 Director 214-20- 7808 March Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City Town or Location Director MD Anne Arundel Severna Park 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 836 Creek View Road 21146 USA within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever III 0.0. Armed Forces?

1 X Yes 2 No If Yes, Give National Year or Dates. Guard 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married White 1 ☐ Yes 2 X No Specify: Specify Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Telecommunication Supervisor other t 12 Be yermit. Page 1 and 2 should be filed.
Department of Health and Mental Hv.
Important: If item 27 is markany injury or other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Potocki Jennie Mae Victor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores Potocki / Wife 836 Creek View Road Severna Park, MD 21146 20b. Place of Disposition (ve.... Glen flaven Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) October 2010 12, Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the History, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ METASTATIC disease or condition resulting in death) SARLOMA (COMPLICATION) Medical Due to (or as a consequence of): 3 mon47 Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ending physician and use as the burial-transit law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Year 5 Other (specify) Day Pregnant at time of death 4 ☐ Pregnant
g ☐ Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 X No Hospital or Attending Physician: The 2 🗆 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 🔀 No HOSPICE မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending Natural Accident 1 Tes 2 🗌 No Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours
To the Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 | Medical Examiner: On the basis of examiner and an analysis in roughly and the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title OR-RAVIN GARG D0064852 101 2010

State

Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

31. Date filed (Month, Day, Year)

DR- RAVIN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GARG

ENCOLOGY CENTER 32. Resistrar's Signature

ANNAPOUS

Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Please Type or Print in Bla				-	_	ble.			
	•	1 - State of Maryland	•	artment of H tificate of D			leg. N2 0 1	0 33945			
Physicia	ın/	Decedent's Name (First, Middle, Last)     William H. Parkinson, Jr.		_		2. Date of Dear	th	3. Time of Death			
Medic Examin	al	4a. Facility Name (if not institution, give street and number)		4h City Town or	Location of Death	October	10 2 4c. County of	2010 11:45 A M			
Examin	ler	Mandrin Hospice House			Harwood		ne Arundel				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last to 15 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct. 10		9. Birthplace (State or Foreign Country) Marvland			
	L	Usual Residence of Decedent  10a. State 10b. County 10c. City, To	own or Loc	cation		1000	13221	10d. Inside City Limits			
Aarylar 8a-f sk tified a	Director	Maryland Anne Arundel	WIT OF LOC		napolis			19€EYes 2 □ No			
th the l 3a or 2 t be no	ral Di	10e. Street and Number 113 Williams Drive		10f. Zip Code	21401		10g. Citizen of W				
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hours fnatura dical E	Completed		6a. Deced	ent's Usual Occupa	ation luring most of worki	ing	16b. Kind of Bus	siness Industry			
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nd 2 sh ealth ar n 27 is ier trau					Lane Cl						
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fitem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1VV Purial 2 Commettee 2 Personal from State Ceme	etery, crem	sition (Name of natory or other place	e) •	Date		City or Town, State			
rmit. Pa spartme portan y injury ICE.		4 Donation 5 Other (Specify)  21. Signature of uneral Service Licensee	22.	Name and Addres	s of Facility Joh	n M. Tay	lor Fun	eral Home			
8 9 E E 6		23a. Part 1. Enter the disease, or complications that caused the death. D						lis, MD 21401			
hysician/		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition			comal	to mo		Approximate Interval Between Onset and Death			
Medical Examiner		resulting in death)  a. Due to (or as a consequence	-	•			•				
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or Arter fter dea irector n by the	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	et, factory, office		28f. Location (St City or Town		or Rural Route Number,			
spital of hours a neral D	Medical C	29a. Certifier Certifying Physician: To the best of my knowledg	e, death o	ccured at the time,	date and place, an	d due to the cau	se(s) and manner	r as stated.			
io the hospital of Attending Priysician: The law, within 24 hours after death.  To the Funeral Director: After this certificate has sompleted filled in by the funeral director, page 2 sompleted filled in by the funeral director, page 2 sompleted filled in by the funeral director.		(Check 2   Medical Examiner: On the basis of examination and only one) Certifying Nurse Practioner: To the best of my known	d/or investi	gation, in my opinion eath occurred at the	n, death occurred at time, date and plac	the time, date an e, and due to the	d place, and due t cause(s) and man	to the cause(s) and manner stated. nner as stated.			
<b>5</b>		29b. Signarure and kile of certifier		29c. License			1 1	(Month, Day, Year)			
		30. Name and address of person who completed cause of death (Item 23s	a) (Type, P	rint)		, 7	^	Ann C			
Stat	e	31. Date filed (Month, Day, Year) 32. Registrar's Signature	4	445/60	NEY SU	nk 410	NUV.	60/11 WO SIMON			
Registra		OCT 13 2010 Keneva	3. A	and							

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ James A. Poggie 2:30 PM 06, 2010 OCTOBER Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death TOWSON SAINT JOSEPH MEDICAL CONTER BALTIMORE Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** . Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 1 3 M 2 F **Director** 212-36-2523 72 10/3/1938 MD Usual Residence of Deceden r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Carroll Hampstead 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Completed by Funeral 4504 Willow View Street 21074 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1955—
If Yes, Give
Year or Dates. 1965 Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 x No Specify: 3 Divorced 4 Divorced Specify: white 1965 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Letter carrier US Postal Service traumatic event, Be Should be file and Mental H 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Philip Poggie Bernadine Mulcahy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Patricia Poggie, wife 4504 Willow View Street, Hampstead, Md. 21074 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1:
Department of I
Important: If it
any injury or or
once. X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hampstead Cemetery 10/11/2010 Hampstead, MD. 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licensee M00741 934 S. Main Street, Hampstead, Md. 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PULMONARY HEMMORHAGE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner CARDIOGENIC Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or linjury death certificate be executed NON ST ELEVATION MYOCARDIAL INFARCTION that initiated events resulting in death) Last attending physician a for use as the buriat-Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Dav 4 Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 SEYERE METABOLIC ACIDOSIS Records, cate has been sig ; page 2 should b Completed 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? SEVERE HYPOXIA 24a Was an autopsy perform 25. Was case referred to medical examiner? of Vital 26. Place of Death (Check only one) 2 X No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 2 Accident Date of injury 28a. 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) 5 Pending Division To the Hospital or Attendia within 24 hours after death. To the Funeral Director: Af completed filled in by the fu 1 🗀 Yes 2 🗌 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🔏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and WJL D 24034 IVA 6+ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE TOWSON 7601 TIMOTHY State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ :10 PM Year Samuel Palmer 2011 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death omico Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
DE Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 0-6-1941 1 🔀M 2 🗆 F Months Director 69 222-24-3178 oortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "--- any injury or other than the marked other than "---10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD 1X Yes 2 No Wicomico Salisbury 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 317 Aspen Drive 21804 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 2 XNo Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bishop/Minister 10 Ministry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eva Robinson Dennard Palmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, M. Catherine Palmer/Wife 317 Aspen Drive, Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Snow Hill Del Cem 10-18-2010 Snow Hill, MD 21. Signate of Fineral Service Licensee 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith Salisbury, Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CHRONIC KIDNEY DISPASR Medical resulting in death) Due to (or as a consequence of): Examiner TYPER TRSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown has been signed to should be 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate ha Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐Ro Other: HOSPICA မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury of injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation To the Funeral Director: completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 29a. Certifier Pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge. enumed at the time, date and place, and due to the 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUP PU WAM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 14 2010 40 AM **Physician** ARIA RALL ADA. octobe /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.
Months | Days | Hours | Min. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number UNK 6. Sex 7. Age (In yrs. last birthday) **Funeral** 11/10/1944 Uruguay 65 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director Uruguay Montevideo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 11300 Uruguay Estigarribia 858 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 X Yes 2 ☐ No Specify ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) International al Hygiene. I other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Organizaition World Bank 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental F 7 is marked of Pages 1 and 2 should be Maria J. Mendy Department of Health and Menti Important: If item 27 is marked any injury or other traumatic en Uruguay J. Parallada 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21 De Septiembre 2511, AP. 202, Montevideo, Uruguay Ilka Parallada/Sister 20a. Method of Disposition
1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cameters, crematory or other place)
Funeral Choices of Chantilly 20c. Location - City or Town, State Date 10/19/2010 Chantilly, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat A Funeral Sen 22. Name and Address of Facility Funeral Choices of Chantilly Gary R. Downer 14522L Lee Road, Chantilly, Virginia 20151 CC0508 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** espirator disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if a yielding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed as the burial-transil Due to (or as a consequence of) Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Day ģ in the past 12 months?
1 ☐ Yes 2 ☑ No Year Pregnant at time of death 5 Other (specify) signed by the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, page 2 should be 2 No 3 Probably 4 Unknown 1 Tes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed 1 🗌 Yes 2 🗆 No 2 Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1X Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 No 3 🗆 DOA 2 ER/Outpatient 5 ☐ Residence 6 ☐ Other (Specify) ၉ nours after death.

neral Director: After this or y filled in by the funeral d 27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? Certification: 5 Pending investigation Natural (Month, Day Year) Injury 1 🗌 Yes 2 No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

5 State

Registrar

/ama 31. Date filed (Month, Day, Year) egistrar's Signatui 282010

30. Name and accress of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

MD

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600 North Wolfe St, Baltimore, MD, 21287

within 2 To the I the

## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

		Item 10a,10b,10c	State of Maryl	•	tment of h		Mental Hy	2011	3	3949
	WCH	D/SH 10/18/2010 Per 1. Decedent's Name (First, Middle, Last)	FH	Oen	meate or	Death	2. Date of D	Reg. No.		3. Time of Death
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Examir	ner		•			•				
		The Brighton Ga 5. Social Security Number 6. Sex		cer yrs. last birthday)	If Under 1 Year	Bethes If Under 24 Hrs.	8. Date of B	Momt	gomes	C Y ce (State or Foreign
Funeral		1 🗆	M 201	Yrs. Vrs.	Months Days		(Month, D	ay, Year)	Country	1)
Director		159-14-0553 Usual Residence of Decedent	95				13/22	/1915	PA-	
fand		10a. State 10b. County	10c.	City, Town or Loca	ition				10d	d. Inside City Limits
5-0036 72 hours effer death with the Maryland natural; or items 23s or 28s4 show steal Examiner must be notified at	ě	MD. Frederic	k	Jeff	erson					1 ☐ Yes 2 ☐ No
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eath	Funeral	3964 Point of F	COCKS ROAC  2. Was Decedent Ever i	n U.S. 13. W	2175		pecify Yes or N	0- USA 14. Rac	e - American	ı Indian,
ter dea iteme	<u>.</u> 5	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No	11	es, specify Cub	Hispanic Origin? (Sp Jan, Mexican, Puerto	Rican, etc.)	i i		
15. or	by	3√Widowed 4 □ Divorced	If Yes, Give X Year or Dates:	10	∐Yes 2∭X No	Specify:		Specify	Whit	e
21215-0036 ad within 72 hours elt giene. r then "neturel", or r the Medical Exam	8	15. Decedent's Educ		16a. Decede	nt's Usual Occup	pation		16b. Kind of Br	usiness/Indu	stry
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within within then	Ē	Elementary/Secondary (0-12)	College (1-4or 5+)		N			Healt	h Car	-
		17. Father's Name (First, Middle, Last)			Nurs	18. Mother's Nan	ne (First, Middle	e, Maiden Surnan		
d be antal	o Be	Joseph Milaz								
Mark mark	F	19a. Informant's Name/Relationship (Typ		19h Mailing	Address (Street	ROSE and Number or Ru	Dica:		State. Zip C	Code)
Maryland of 2 should be file ith end Mental Hy 27 is marked oth				1 000 S						
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To a special strategy of or or or or or or or or or or or or or		1 □XBurial 2 □ Cremation 3 □ Re	emoval from State	cemetery, crema	itory or other pla	ice)				
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Baltimore, permit. Peges 1 e Depertment of Hei mportant: If Item in y injury or othe anse.		21. Signature of Funeral Service License	θ	22.	Name and Addre	ess of Facility Fr	ank Du	cca Fu	neral	town,PA Home
		Larro J. Stacker	Sa 14010	35 16	22 Men	oher B1	vd. Jo	hnstow	n, Pa.	15905
		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the c	leath. Do not enter	the mode of dyi	ng, such as cerdiac	or respiratory	arrest,	A	Approximate nterval Between
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/Medical		Immediate Cause (Final disease or condition	PNE	ALLASMIT	*					
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68 tifice of ph es th	<u>8</u>	resulting in death) Last							I I	
Geath certificel e attending physic for use es th	Physician/M	d.							1.	
deat deat e att	S	Part II. Other significant conditions cont	ributing to death but not	resulting in the und	erlying cause gi	ven in Part I.	23b. Dic	I tobacco use co	ntribute to t	he cause of death?
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Division of Vital Re To the Hospital or Attending Physician: The it within 24 hours effer death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edicai		cian: To the best of my er: On the basis of exam							
the mple	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		29d. Date signe	d (Month D	av Year)
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0411.2	,	30. Name and address of person who con	npleted ceuse of death (	Item 23e) (Type, P	rint)		10.0	/ /		
DU-2		M-RUAJ GNOSH M	10,14812	PHYSIC	iams i	MWE#	-16 ( R	CRVILLE	e) no.	25.40E
Sta		31. Date filed (Month, Day, Year)  OCT 18 201	32. Registrar's S	ignature		/				
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DHMH 16 Rev 6/9	5			ORIO	GINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ( 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Marcus A. Riggs, Jr. utbe 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** The Johns Hopkins Hospital 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 5 1 XM 2 □ F Maryland Director 218-87-0067 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Director Temple Hills Prince George's Maryland 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ò filed within 72 hours after death with "natural", or items 23a or 3107 Good Hope Avenue 20748 Apt. # 309 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify. Specify: Black δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 7 is marked other than "natur traumatic event, the Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 0 none none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event, once. Be Marcus A. Riggs, Sr. Saleathia Phillips ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3107 Good Hope Avenue Apt. # 309 Temple Hills, Md. Saleathia Pendarvis - Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State October 1 XBurial 2 Cremation 3 Removal from State Heritage Memorial 4 ☐ Donation 5 ☐ Other (Specify) 2010 Waldorf, Maryland 21. Signature of Funeral Service I 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 20019 23a. Part 1 Enter the disease, or complications that caused the death, shock of teart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final ardiac Physician disease or condition resulting in death) /Medical Du lo (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner as a consequence of) as the burial-transit and Due to (or as a consequence of): Box 68760. attending physician certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy in the past 12 months? Year detached for Month Day Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 1 Yes 2 No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \sum Nursing Home 1 ☐ Yes 2 XNo Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) ည After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: or Attending 1 Natural 2 Accident 5 Pending investigation Injury e Hospital or Attendir 24 hours after death. e Funeral Director: Af death. 1 Yes completely filled in by the Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) within 24 and manner stated 29b. Signature and titl

State Registrar

DHMH 17 Rev 1/2001

Name and addres

31. Date filed (Month, Da

OCT 1

600 North Wolfe St, Baltimore, MD, 21287

of person who completed cause of death (Item 23a) (Type, Print)

32. Regis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11)65 ()Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 F (Month, Day, Yeav 20 Months Days Hours Min. 1928 578-34-9067 **Director** 82 Orkney Springs, VA Usual Residence of Decedent or 28a-f show notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Gambrills 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Completed by Funeral 730 Maryland Route 3 South 21054 USA ural", or items? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Force 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 ₩ Widowed 4 □ Divorced Year or Dates Ith and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical! 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edward Franklin Moomaw Sally Hepner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary A. Ridgeway / Son 1748 Thistle Ct., Gambrills, MD 21054 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5 1 X Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or George Washington Cemetery 10/15/2010 Adelphi, Maryland 4 Donation 5 Other (Specify) 21, Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final END Proteing Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year Yes 2 40 the 9 Unknown Unknown ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ၉ Inpatient 2 ER/Outpatient 3 DOA Director: After this of in by the funeral dir 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death ė 28a. Date of injury Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work? 1 Natural 5 Pending injury Certifical Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) 7 M no completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year 32. Registra State 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend#23b. PerPHYS. PGC10-25-10cr Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Abdul Aziz Rashid 0255AM Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Lanham Doctors Community Hospital 9. Birthplace (State or Foreign, Country) West Africa Sierra Leone, Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** Months Days Hours March 29,1959 Director 634-38-2383 51 Usual Residence of Decedent 10a. State 10b. County ortant; If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Yes 2 No New Carrollton Maryland| Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20784 Sierra Leone, West Africa 5520 Karen Elaine Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc Completed by 1 Never Married 2 Married **Black** 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 7: ment of Health and Mental Hygiene. tant; If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 6 None None vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Honorable Yewah Satta Bangura Karim Rashid 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Ccde) 20784 permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau once. Mathias Bannister (Uncle) 5520 Karen Elaine Drive; New Carrollton, Maryland 20c. Location - City or Town, State Sierra Leone, 20a. Method of Disposition 20b. Place of Disposition (Name of Date X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Sumbuya Cemetery Nov.6,2010 West Africa 22. Name and Address of Facility R. N. Horton Company Morticians, 21. Sig. Ture of Funeral Service Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ ardiac disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and debached for use as the burial-trans Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 272 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performed 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ ER/Outpatient 3 DOA 1 Inpatient 2 Z Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at After 5 Pending (Month, Day, Year) Natural 2 Accident
3 Suicide
4 Homicide 2 🗌 No 1 Tes Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20706 Road 31. Date filed (Month, Day, Y State 32. Registrar's

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, RITA CECELIA RHOE 2. Date of Death 3. Time of Death .Day2010 ofth. 17, **Physician** 1:25AMM /Medical 4a. Facility Name (If not institution, give street and number)
GOLDEN LIVING CENTER 4c. County of Death 4b. City, Town, or Location of Death Examiner WASHINGTON HAGERSTOWN 5. Social Security Number 235-12-1057 If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 172977918 94 WEST VIRGINIA 1 □ M 2 □ XF Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits MD WASHINGTON SMITHSBURG 1 ☐ Yes 2 ☐ No r 28a-f sh notified Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? a or 11623 CRYSTAL FALLS DRIVE 21783 USA "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☐No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗖 No MHITE Specify: Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important; If Item 27 Is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CHILD CARE GIVER PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LILLIE RIDENOUR ALBERT CLAGETT KEPLINGER ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11619 CRYSTAL FALLS DR., SMITHSBURG, MD 21783 CAROLYN SMITH (DAUGHTER) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ROSEDALE CEMETERY MARTINSBURG, WV 2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821, 327 W. KING ST., MARTINSBURG, WV 25402 beld 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MINIS Commany Outery /Medical Due to (or as a nsequence of): Examiner Sequentially list conditions, if any least the following cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an page 2 s has autopsy certificate 2 🔽 1□ Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Certification: To 1 🔲 Inpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After the Hospital or Attending Natural 2 Accident 5 Pending investigation To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 Tes 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated.

State Registrar 31. Date filed (Month, Day, Year) 0CT 28 2010

29b. Signature and title of certifier

Marysen

null Street Heigesterm 190 368 DSHAFT

30. Name and address operson who impleted cause of eath (Item 23a) (Type, Print)

29c. License number

D28365

29d. Date signed (Month, Day, Year)

10-07874 Jason D Riley Please Type or Print in Black Indelible Ink. Lisu ... Pies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Marjorie Schlueter October 5:38A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Glen Burnie Anne Arundel Greater Baltimore Washington Med Center Social Security Number If Under 1 Year 8. Date of Birth 7. Age (In vrs. last birthday) If Under 24 Hrs. Funeral 9. Birthplace (State or Foreign 1 M 2 TXF 96 216-22-0736 ORTO') 1070971914 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 3a or 28a-f sh t be notified Crofton Maryland Anne Arundel 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA items 23a 21114 1725 Dana St. Funeral Examiner must 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give ö þ 1 Never Married 2 Married 1 Yes 2 X No Specify: Specify: White Completed 3 XWidowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Baltimore, Maryland 21215-(Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Restaurant Manager Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Blain Schraeder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steve Dulin - Son 1725 Dana St., Crofton, MD 21114 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Baltimore Crematory 1 Burial 2 X Cremation 3 Removal from State 10/13/2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician, disease or condition Medical resulting in death) (or as a consequence of) Due to Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence cause. Enter Underlying Cause (Disease or linjury that initiated events attending physician and for use as the burial-transit To the Hospital or Attending Physician. The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

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9 Unknown Dav Year cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy 2 🗌 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes Other: ျှ 2 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Deat Date of injury Certificate: 28b. Time of 28c. Injury at Natural Accident (Month, Day, Year) 5 Pending injury 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License number 30. Name and add

State Registra

23a) (Type, Print)

person who completed cause of death (Item

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Desedent's Name (First, Middle, Last) 2. Date of Death Physician/ BIERT 0150 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Mandrin Chesapeake Hospice House Harwood 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 M 2 1 4/30/1918 West Virginia 92 Director 135-14-0155 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County . Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. It ant If flew 22 is marked other than "natural", or items 23a or 28a-f sho lant if flew 22 is marked other than "natural", or items 23a or 28a-f sho lant flew 21 in yor or other traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No Maryland Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? Funeral USA 20906 15101 Interlachen Drive, Apt. 320 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 □ No If Yes, Give Year or Dates 1942-43 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify. White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8th Salesman Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gaetano Sole Rose Esposito 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 Mary C. Sole/ Wife 15101 Interlachen Dr., Apt. 320, Silver Spring,MD permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify)

21. Signature (Specify) MD Veterans Cemetery 10/14/10 Crownsville, MD 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Completed filled in by the funeral director, page 2 should be detached for use as the hurial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No 1 Yes 2 No Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: ၉ 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other SAMDRIN 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of PILL 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certi 112010 10+1 who completed cause of death (Item 23a) (Type, Print) Name and address of perso NNAPOLO · La GENTAM DEFENSE 31. Date filed (Month

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend I tem# 28e-f. per me gg17 7-29-11 sm State of Maryland / Department of Health and Mental Hygiene | | | For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Scymanski, Robert J. Sr. Medical 2010 2.45a 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Center Towson . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 🗆 F Director 135-12-7926 91 /17/1919 Man Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notifled at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Upperco MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral USA 3121 Mt. Zion Road 21155 death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 Yes 2 No WWII Armed Forces' Black, White, etc. þ 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 72 hours after 1 Yes 2 No Specify: Specify: white "natural", 3 Divorced Completed Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene.

Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Building Human Relation Executive materials Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ and 2 should be Health and Menta Joseph Scymanski Elizabeth Katherine Raleigh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce, Kathleen Scymanski, wife 3121 Mt. Zion Road, Upperco, MD. 21155 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 10/14/2010 4 Donation 5 Other (Specify) VAlley Mem. Dulaney Timonium, MD Signature of Funeral Service Licens ee 22. Name and Address of Facility Eline Funeral Home M01072 St., Hampstead, Md. Main 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Enysician/ Complications disease or condition resulting in death) AUS Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading from editions cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnan in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? anchectic 24a. Was an autopsy perform Yes 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 D Other (Specify) ha (PIO 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗌 Natural 5 Pending injury Fe1 0450417,2010 1 Yes 2 No Accident Investigation 5:00 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

parking lot Sheet 28f. Location (Street and Number or Rural Route Num City or Town, State) 2135 York Rd. 4 Homicide determined Timonium, Md. Medical PCcrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) JL AVIX 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21204 +10 31. Date filed (Month, Day, Year) State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month SCARBROUGH O A M SCOTT CHARLES 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MANOKIN PRINCESS SOMERSET MANOR 11974 GOGENILL TERRACE 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1**X**M 2□ F Months Days Hours Min. 336 20 2617 ILLINOIS MARCH 30 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1XYes 2 □ No VIRGINIA ACCOMACK CHINCOTEAGUE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? BEEBE 7478 ROAD 23336 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: WHITE 1 ☐Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) ZYEARS Elementary/Secondary (0-12) AVIATION DESIGNER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) GEORGE SCARBROUGH LILLIE MEGREW 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SCARBROUGH 7478 BEEBE SHIRLEY B. IFE CNINCOTERGUE RCAD VIRGINIA 23336 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) DAISEY DLT. 12 2010 CHINCOTEAGUE, VIRGINIA CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fox & HOLSTON FUNGRAL HOME SO49 CHICKEN CITY ROAD CHINGOTEAGUE VA. 23336 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 54 cars Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery

**Physician** /Medical **Examiner** 

permit. Pages 1 and 2 should be fi Department of Health and Mental I Important: If Item 271s marked ot any injury or other traumatic ever sonce.

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

ral", or items 23a or 28a-f shov Examinar must be notified at

Director

by Funeral

Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Examine and burial-tra attending physician Physician/Medical signed by the a þ page 2 should Completed Be Certification: To

law requires that the death certificate be execute

Division of Vital Records, P.O. Box 68760.

iours after death.

neral Director; A
filled in by the fi

Hospital or Attending Physician: 24 hours a Funeral L Medical completely To the within 2 State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at time of death 5 ☐ Other (specify)	Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	3e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 ᠯ No 3 □ Probably 4 □ Unknown
		ta. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?  □ Yes 2 ⋈ No 1 □ Yes 2 □ No
25. Was case referred to medical examiner?	26. Place of Death (Chec	ck only one)
1 ☐ Yes 2 🗹 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5	☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. De	escribe how injury occurred
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, factory, office 28f. Loc	cation (Street and Number or Rural Route Number, ty or Town, State)
29a. Certifier (Check only (Check only (Check only) (Check only)	hysician: To the best of my knowledge, death occurred at the time, date and place, and duminer: On the basis of examination and/or investigation, in my opinion, death occurred at the	e to the cause(s) and manner as stated. ne time, date and place, and due to the cause(s)

29c. License numbe

DO51359

29d. Date signed (Month, Day, Year)

October 11th 2010

DHMH 17 Rev 1/2001

NATESAN

ST, SALISIBURY, MD

32. Registrar's Signature

DR USHA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. DIVISION

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2010 Franklin Douglas Sheets 0919 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1359 Turkey Point Road North East Cecil Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Hours 1 X M 2 □ F 001 24, Year 942 West Virginia 230-54-6823 Director 67 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Maryland Ceci1 North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21901 1359 Turkey Point Road United States 12. Was Decedent Ever in U.S. Armed Forces? 1960 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 N 1963 "natural", or Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify 3 Widowed 4 X Divorced If Yes, Give Specify: White Year or Dates 72 hours 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore, Maryland 2121 d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Accountant Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Eli Sheets Lucille Lela Hvlton permit, Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melissa Russell/Daughter 1355 Turkey Point Road, North East, MD 20a. Method of Disposition
1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State R. A. Ferris & Co., Inc. West Chester, PA 4 Donation 5 Other (Specify) 15, 2010 Signature of Funeral Service Licenses 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ amous disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 1 Yes 2 9 Unknown page 2 should be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy perform death? this certificate ☐ Yes To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one, 2 No Other: 1 Yes Certificate: To ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatient 2 I 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4  $\square$  Homicide determined 29a. Certifier Macertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

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Mar	shou n and 7 is m raum		19a. Informant's Name/Relations	hip (Type, Print)							-	ın, State, Zip C	Code)
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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service		1 dape in		ne and Addres						<i>DL</i>
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ğ ×	th cert ttendir or use	ian/I	23b. Was decedent pregnant in the past 12 months?		2 Fetal death			/			23d.	Date of delive	ery Day Year
. B	the at	Physician/N	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of death	5 ∐ Oth	er (specify)					MOTH	Day leai
<u>Р</u>	that th	by Ph	Part II. Other significant conditi	ons contributing to death b	ut not resulting in t	he underl	ying cause give	en in Part I.	236	e. Did toba	acco use c	ontribute to th	e cause of death?
<del>S</del>	quires en sign	ted b			21 - 12				_	1 🗌 Yes	s 2 N	lo 3 🗆 Prob	pably 4 Unknown
COL	aw rec as be	Completed							248	a. Was an autopsy		prior to cor	osy findings available mpletion of cause of
æ	rsician: The law s certificate has l lirector, page 2 s										ned? No	death? 1 Yes	2 🗆 No
ita	sician certifi irector	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:			Othe	r.	Check only on				
o   	g Phy er this eral d	te: To	27. Manner of Death	28a. Date of injur		e of	28c. Injury	at		•	v injury occ	Other (Specify) curred	
on	eath. or: Aft	fica	1 Natural 5 Pendin 2 Accident Investi 3 Suicide 6 Could	gation	, 76a) IIIJu	M	work?	res 2 🗆 No	o				
Division of Vital Records, P.O. Box 68	or Att after d Direct in by I	Certificate:	4 Homicide detern		iry - At home, farm c. (Specify)	, street, fa	ctory, office			ation (Stre or Town,		mber or Rural	Route Number,
Ω	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	edical	29a. Certifier 1 Certifying	Physician: To the best of	my knowledge, de	ath occure	ed at the time,	date and place	ce, and due to	the cause	e(s) and ma	anner as state	d.
	the Ho lin 24 the Fu	Med		Examiner: On the basis of ex Nurse Practioner: To the									
	To To To To To To To To To To To To To T		29b. Signature and title of certifie	ń.			29c. License		434	29	d. Date sig	gned (Month, E	Day, Year)
			20. Name and address	who completed cause of de	eath (Item 22a) (Tim	ne Print\	H00	562	41		10-	15-10	-
,	2746		30. Name and address 314 Franklin	who completed cause of di		e, Print)	lin .	UD	218	11 (	raic	7 John	ISON MID
	Stat		31. Date filed (Month, Day, Year)		ar's Signature	,						1	
	Registra	ir	OCT 1 4	ייין מדמפ	DI .	BOR. N.	4						

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	for State Of IVIA  State Registrar		tificate of Death	and Memains	Reg. No.	22061
	Physicia Medic		Decedent's Name (First, Middle, Last)     MARY LOU THARP			2. Date of Do Month	eath Year	3. Time of Death ) 16/7 M
	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location	of Death	4c. County of Dea	
anger de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina de la constantina della constantina della constantina della constantina della constantina della constantina della constantina della constantina della constantina della constantina della constantina della constantina della constantina della constantina della constantina della constantina della constantina della constantina della constantina della constantina della constantina della	Funeral		WESTERN MD REGIONAL MEDICAL 5. Social Security Number 6. Sex 7. Age	CENTER (In yrs. last birthday)	CUMBERLAND If Under 1 Year If Under			rthplace (State or Foreign
	Director		215-26-9554 1 M 2 F 8	32 Yrs.	Months Days Hours	Min. (Month, D. 12-12-	1927 MAF	RYT,AND
700	show	tor		10c. City, Town or Loc	ation			10d. Inside City Limits
Man	28a-f	Director	MD ALLEGANY	FROSTBURG				1 🂢 Yes 2 □ No
within 72 hours after death with the Mandand	tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral D	10e. Street and Number 4 POWELLS LANE APT B4		10f. Zip Code 21532		10g. Citizen of What C	ountry?
1000	or item	by Fu	11. Marital Status  1	lf.	/as Decedent of Hispanic Ori Yes, specify Cuban, Mexicar	igin? (Specify Yes or No n, Puerto Rican, etc.)	14. Race - Am Black, Whi	
	"natural", or items	ted b	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1	Yes 2 No Specify.	:	Specify: V	HTTE
5 2	n "nat Aedica	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give ki	ent's Usual Occupation ind of work done during mos ) NOT use retired)	t of working	16b. Kind of Business	s Industry
7 I	giene.		Elementary (Seconday (0-12) College (1-4 or 5+)		MEMAKER		OWN HO	OME
E filed	salound be lied within it and Mental Hygiene. 7 is marked other than traumatic event, the M	To Be	17. Father's Name (First, Middle, Last)			er's Name (First, Middle		
should be	nd Mer		JOHN LEWIS  19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	AN Address (Street and Number	NIE WHITE U er or Rural Route Numb		ip Code)
and a st	- N -		JANE FRAZIER DAUGHTER	I `	ERENITY CIRCL			
2 2 2	. 0		20a. Method of Disposition  1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispos cemetery, cremi CUMBERLANT	atory or other place)	Date 10-23-2010	20c. Location - City o	
	Department Important: I any injury o		21. Signature of Funeral Service Licensee  Han M Sowers M	200 64 7	Name and Address of Facility  MATN ST	TY SOWERS FURE FROSTBURG.	JERAL HOME, MD 21532	PA
			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	he death. Do not enter			rrest,	Approximate Interval Between
P	nysician Medical		Immediate Cause (Final disease or condition resulting in death)	ovascu	LAR ACC	TUBO		Onset and Death
E	xaminer		CHRONIL	ATKIA1	L FIBRILL	ATION		
7	÷.	Examiner	of any, leading to immediate cause. Enter Underlying	consequence of).				
cate be executed	physician and s the bunal-transit	Exar	Cause (Disease or linjury that initiated events resulting in death) Last c. Due to (or as a continuous continuous)	consequence of):				
e pe e	iysiciar ne buri	ledical	d					
			IF FEMALE: 23c. If yes, outcome of	pregnancy				
The law requires that the death certif	the attending poshed for use as 1	Physician/N	23b. Was decedent pregnant in the past 12 months?  1	☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)		23d. Date of de Month	elivery Day Year
es that th	been signed by the s should be detached		Part II. Other significant conditions contributing to death but  H. YPERTENSION	not resulting in the un	nderlying cause given in Part		tobacco use contribute t	o the cause of death?
requir	been s	letec				24a. Was		utopsy findings available completion of cause of
The law	cate has page 2	Completed by				auto perf 1 🗌 Yes	ormed? death?	completion of cause of
Attending Physician:	certificate irector, pag	Be c	25. Was case referred to medical examiner?  1		_ Other:	th (Check only one)		
a Phy	ter this	te: To	27. Manner of Death  1 Natural 5 Pending (Month, Day, (Month, Day, )	t 2 ER/Outpatient 28b. Time of injury	28c. Injury at work?		dence 6 Other (Spe how injury occurred	cify)
tendir	death. tor: Af the fu	Certificate:	2 Accident Investigation		M 1 ☐ Yes 2 ☐			
ital or At	irs after or ral Direct led in by		4 Homicide determined 28e. Place of Injury building, etc. (	r - At home, farm, stree (Specify)	et, factory, office	28f. Location ( City or To	Street and Number or Ro vn, State)	ural Route Number,
he Hospi	within 24 hours after death.  To the Funeral Director After this certific completed filled in by the funeral director,	Medical	29a. Certifier 1	mination and/or investig	gation, in my opinion, death or	ccurred at the time, date	and place, and due to the	cause(s) and manner stated.
Tot	To 1		29b. Signature and title of pertifier		29c. License number	76	29d. Date signed (Moni	
			30. Name and address of person who completed cause of dea	th (Item 23a) (Type, Pr	D0066	000	10-19-3	2010
			Olaide Ajayi MDI	2501 Will	nubrook Rd	Cumber	land MD	21502
	Stat Registra		31. Date filed (Month, Day, Yeán) 32. Registrar's	Signature				

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		<b>"</b> For	Plea	State of N				of Health and	•		•		962	
		<ul><li>State</li><li>Registrar</li></ul>				Ce	rtificate	of Death		Reg. N	2 U I U	00	J U L	
Physicia Medic		1. Decedent's Name Miriam		, Last) RREYER					2, Date of Do Month	D	Year 201	3. Time	of Death	
Examin		4a. Facility Name (if	not institution,	give street and number)			4b. City, To	own, or Location of De	eath	4	c. County of Dea	ith		
		WASHING 5. Social Security Nu	GTON Co	unty Hospit	al	ast birthday)	H:	agerstown Year If Under 24 F	ire Detect Di		Washington h 9. Birthplace (State or Foreign			
Funeral Director		247-38-95		1 □ M 2 🗓 F	82	Yrs.			irs. 8. Date of Bi in. (Month, Di March	rtn a <i>y, Year)</i> <b>? ?</b>	1928 Sot	nnplace (State ountry)	or roreign	
Mo.		Usual Residence of	Decedent						Haren		1720 500			
yland -f shc ed at	ctor	10a. State	10b. County		10c. Cit	y, Town or Lo	ocation						City Limits	
e Mar r 28a notifi	Dire	Maryland  10e. Street and Num		ngton	I	lagerst	town 10f. Zip C	Pa da		10.0			Yes 2 □ No	
vith th	Funeral Director										Citizen of What C	ountry?		
eath v	-nu-	719 Largo	DLIVE	12. Was Decedent			Was Deceden	21740 nt of Hispanic Orlgin?			14. Race - Am	erican Indian,		
fter d	þ	1 Never Marrie		Armed Forces' ied 1 ☐ Yes 2 X If Yes, Give			If Yes, specify 1 ☐ Yes 2 <b>)</b>	Cuban, Mexican, Pu	erto Rican, etc.)		Black, Whi			
ours a tural	Completed	3 🛛 Widowed 4		Year or Dates.						_	Specify: Wh:			
72 hc n "na nedic	nple		cify only highe	t's Education st grade completed)		(Give	dent's Usual ( kind of work ( O NOT use re	done during most of v	vorking	16b.	Kind of Business	Industry		
within giene. er tha the I		Elementary/Seco	onday (0-12)	College (1-4 or	5+)	1	Ceacher	ŕ		Bo	ard of 1	Educati	ion	
filed \alpha all Hyg	Be (	17. Father's Name (F	irst, Middle, L	ast)					Name (First, Middle					
Ment Ment arke	욘	John Cuma	lander					Anita						
Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Healih and Mertall Hygiene. ant. If fire Z7 is marked other than "natural", or items 23a or 28a-f show ant. If fire Z7 is marked other than "natural", or items 20a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Na						Street and Number or						
and 2 Healt tem 2		Fred Vorr		Son	20h F		0 0ak osition (Name	Ridge Dri	ve, Hagei		wn, Md. Location - City o			
age 1 ent of ht: If it y or o			Cremation	3 Removal from State	e c	emetery, crer	matory or othe	er place)			,	·		
2 P T T		21. Signature of Fun			Has			matory 10/ Address of Facility	Minnich		erstown		Land	
permit Depar Impor any in			Coll	MMum	me	/		Wilson Bl					21740	
				complications that cause		h. Do not ent	er the mode o	of dying, such as card				Approxim	nate	
Physician/		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or a a consequence of): //												
Medical Examiner		resulting in death)		Due to for	a consequ	uence of):	Pic	00	dol	e		1 -0	L. 1. 11	
	er	Sequentially list conditions, if any, leading to immediate Due to (c) as a c nisequence of):												
rted d Insit	Examiner	Cause (Disease or linjury											elle	
be executed ician and burial-transit		that initiated events resulting in death) L		Due to (or as	a consequ	ience of):	00-	Car Chi	ADAC-			1/1,10	a. A.	
	dical		'	d	cu (	<u>e                                    </u>	10	on cu	z jusn	2		vyce	a G	
To the Hospital or Attending Physician: The law requires that the death certificate in within 24 hours affected.  To the Funeral Director. After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE:		23c. If yes, outcome	of pregna	ncv		,	é			V		
atth co atten for us	cian	in the past 12 m	nonths?	1 Live Birth 4 Pregnant	2 🗌 Feta	al death 3	Ectopic pre Other (spec			33	23d. Date of de Month	Day	Year	
the de sy the ached	hysi	9 Unknown		9 Unknown										
s that gned b		Part II. Other signific	cant condition	ns contributing to death	but not res	ulting in the L	inderlying cau	use given in Part I.	. 11		use contribute to			
equires	Completed by			Callett (	afo	Epp.	NY	Muga	<u></u>	Yes 2	2 ✓ No 3 ☐ F	robably 4 [	Unknown	
law re has be e 2 sh	nple			<del>-</del>		-			24a, Was	psy	prior to	itopsy finding completion o	s available f cause of	
: The icate I									1 🗆 Yes	ormed?	death? No 1 ☐ Ye	s 2 No		
sician certifi rector	) Be	25. Was case referred examiner?  1  Yes 2		Hospital:				26. Place of Death (Control Other:						
g Phy er this eral d	<u>و</u> :	27. Manner of Death		28a. Date of inj	ury	28b. Time of	nt 3 🗆 DOA 28c.	4 ∟ Nursing . Injury at	Home 5 Resi			cify)		
ending sath. or: Afte	ficat	1 Natural 2 Accident	5 Pending	ation	ay, rear)	injury	м	work? 1 Yes 2 No						
r Atte	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ∐ Could n determi				eet, factory, o	ffice	28f. Location (		nd Number or Ru	ral Route Nur	nber,	
pital c		29a. Certifier / 1	Cartificina	Dhusialan Tathahart	f l 1			- No. of the last	1	- / >				
24 hc 24 hc Fun eted	Medical	(Chleck / 2	Medical Ex	Physician: To the best o caminer: On the basis of Nurse Practioner: To the	examinatior	and/or invest	tigation, in my	opinion, death occurre	ed at the time, date a	and plac	e, and due to the	cause(s) and r	nanner stated.	
To the within To the comp	2	29b. Signature and ti			Door of fing	, knowledge, t		icense number	place, and due to ti		ate signed (Mont			
		Mal	Do.	gwn	D	4	1	004502	37	00	£15	2010	9 -	
(I . (=		30. Name and addres	ss of person w	ho completed cause of	death (Item	23a) (Type, F	Print)	= aulio	Lau ,	87	HAG	MDZ	17wn	
H-6 State		31. Date filed (Month	Day Year	32. Registr	rar's Signat	ure Da	140	- Court	7 000 2		•		170.	
Stat Registra	ır	31. Date filed (Month	UCT 18	2010	o oignat	A	had!	0						

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# Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	-	State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No. 2							10	33963					
Physicia Medic		1. Decedent's Name Annelie							Month Day Year			3. Time of Death 7:24 P M			
Examin		4a. Facility Name (if not institution, give street and number)  295 Powell Circle							Town, or Location of Death			4c. County of Death Worcester			
Funeral Director						ast birthday Yrs.	) If Und	If Under 1 Year If Under 24 Hrs.			8. Date of Birth 9. E Dec 6, 1924			9. Birth Coun	olace (State or Foreign tryGermany
		Usual Residence of Decedent  10a. State  10b. County				85 Yrs. Dec. 6", 1924								I 0d. Inside City Limits	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fire Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	MD		Berlin									1 ☐ Yes 2 🛣 No		
	eral D	10e. Street and Num 295 Powe		·1e		10f. Zip Code 10g. Citize 21811							Citizen of	What Cour	ntry?
	Completed by Funeral	11. Marital Status  1 Never Marri 3 Widowed	ied 2 🗆 Marrie	12. Was Dece	2 <b>X</b> No	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)							ce - Americ		
		(Sper	-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working iffe. DO NOT use retired) Homemaker  Homemaker							Home				
	To Be	17. Father's Name (First, Middle, Last) Walter Baucks				18. Mother's Name (First, Middle, Maiden Surname) Paula Stracke							e)		
		19a. Informant's Name/Relationship (Type, Print)  Susanne A Hoshino-Daughter  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 295 Powell Circle Berlin, MD 21811													
artment of Fortant: If ite injury or ot		20a. Method of Disposition  1							rd, D						
Impo any once		him	1110	1cheoc							Berlin,				
within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit and property in the funeral director.	dical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death  Onset and Death  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									Interval Between				
	Physician/Medical	in the most 10 months? 1 Live Birth 2 Lifetal death 3 Lifetal Ectopic pregnancy							ate of deliver	e of delivery hth Day Year					
	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute  1 □ Yes 2 □ No 3 □													
	Completed	autopsy prior performed? death								psy findings available mpletion of cause of 2  No					
	Certificate: To Be	examiner? 1  Yes 2  27. Manner of Death 1  Natural 2  Accident	No 5 Pending Investiga	28a. Date of (Mont.										)	
ins after de ral Directo lled in by th		building, etc				: (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
ithin 24 hou o the Fune ompleted fi	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated and place, and due to the cause(s) and manner as stated and place, and due to the cause (s) and manner as stated and place, and due to the cause (s) and manner as stated and place, and due to the cause (s) and manner as stated and place, and due to the cause (s) and manner as stated and place, and due to the cause (s) and manner as stated and place, and due to the cause (s) and manner as stated and place, and due to the cause (s) and manner as stated and place, and due to the cause (s) and manner as stated and place, and due to the cause (s) and manner as stated and place, and due to the cause (s) and manner as stated and place, and due to the cause (s) and manner as stated and place, and due to the cause (s) and manner as stated and place, and due to the cause (s) and manner as stated and place, and due to the cause (s) and manner as stated and place, and due to the cause (s) and manner as stated and place, and due to the cause (s) and manner as stated and place, and due to the cause (s) and manner as stated and place, and due to the cause (s) and manner as stated and place, and due to the cause (s) and manner as stated and place, and due to the cause (s) and manner as stated and place, and due to the cause (s) and manner as stated and place, and due to the cause (s) and manner as stated and place, and due to the cause (s) and manner as stated and place, and due to the cause (s) and manner as stated and place, and due to the cause (s) and manner as stated and place, and due to the cause (s) and manner as stated and place, and due to the cause (s) and manner as stated and place, and due to the cause (s) and manner as stated and place, and due to the cause (s) and manner as stated and place, and due to the cause (s) and due to the cause (s) and due to the cause (s) and due to the cause (s) and due to the cause (s) and due to the cause (s) an							use(s) and manner stated. ated.						
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84			05 Pe	ho completed cause	~ Por	<sup>23a)</sup> (Type	Print)				`~~`	<u>ا</u>	1 02	, L	arrane Irah
Stat	te	31. Date filed (Month	OCT 1 4	2010 32. Rg	gistrar's Signati	ure	back							(	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 33964 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SUSAN 1250 PM Physician/ ACORD OCTOBE2 2010 Medical 4b. City, Town, or Location of Death
BALTIMOUS 4a. Facility Name (if not institution, give street and number)
THE JOHNS HOPKINS BAYVIEW MEDICAL 4c. County of Death **Examiner** If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days (Month, 1 🗆 M 2 🗹 F Months VIRGINIA 212-54-7639 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 Yes 2 No STON 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1398 Sigtaid Funeral "natural", or items 23a 160 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates Specify: WhiTi 3 Widowed 4 Divorced injury or other traumatic event, the Medical 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Be Mother's Name (First, Middle, Maider 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked t any injury or other traumatic eve once. HEDGECOTH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print William A ASBURY 1398 SIGHLID CT. EASTON, MD. 21601 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 10-26-10 ODENTION, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Avan Py Truteset Hout 21. Sign re no ox ate Between CHOINDUNTAN RO, PASSIGNA, MID-Z1122 Part 1. Enterente disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

The diate Cause (Final lass or condition as a SON TBSA BULL REQUILE EXCISION AND Great the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the sta Immediate Cause (Final TBSA BURN REQUIRE EXCISION AND GRAFTING 8 DAYS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner HYPOTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) RAPID ATRIAL FIBRIL Cause (Disease or iiniury attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d, Date of delivery 23b. Was decedent pregnant Month Day signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> STAGE RENAL DISEASE 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate has 1 Yes 2 10 ☐ Yes 2 ☐ 💥 o 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursin Home 5 Residence 6 Other Secily ျ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: SMOKING ON OKYCOU, CLOTH OF FIRE 
 □ Natural 5 Pending 1400 M 1 ☐ Yes 2 → No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1398 Sigfrid Court Easton, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
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| Description of the basis of examination and/or investigation and the basis of examination and the basis of exami Stepaza 29b. Signature and title of certifier AF 2664200 > STJEPANOVIC ZELYKO, FELLOW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTER - AJE, 21224 BALTIMORE ZELJKO STIEPAMOVIC 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

AMEND TEM#19b, perffi, 6908, no /Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien () State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010° MILDRED FAITH ARNAL Month Oct 9:55P M Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore White Marsh Brightview Assisted Living 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday, 6. Sex **Funeral** Days Year 1915 Hours Min. OCT. Day, Mary Tand 1 M 2 F 95 Director 213-38-5611 Usual Residence of Decedent Show 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I frem 27 is marked other than "natural", or items 23a or 28a-f sho important: I frem 27 is marked other than "natural", or items be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Baltimore County 1 Yes 2 X No Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21237 8100 Rossville Blvd. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. Be Completed by 1 Never Married 2 Married Specify: White 21215-0036 1 ☐ Yes 2 X No Specify: 3XX Widowed 4 ☐ Divorced Year or Dates 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Baltimore County Elementary/Seconday (0-12) College (1-4 or 5+) Board of Education School Teacher yrs. 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) မ Mary A. Krichton Harry C. Heuisler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Aumber of Rural Reyte Number, City or Town, State, Zip Code) 1191 W. Skyview Landing Hernando, Fl. Faith Boguski (Daughter) Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) XX Burial 2 Cremation 3 Removal from State Parkwood Cemetery 10-29-10 Baltimore, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service ticensee 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Balt Sassaks Maryland Baltimore. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy Live Birth 2 - Fetal death in the past 12 months? Month Day for 5 Other (specify) Pregnant at time of death 1 Yes 2 5 2 **N**o as been signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 🗌 No 1 Yes this certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Division of Vital Be examiner? Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: After 1 Natural 5 Pending Accident Investigation after death

Director: A
d in by the f 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de **To the Funeral Directo** completed filled in by th determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day, 29c. License number PR ELLIOT CITY 21042 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OSS CHE VROLET 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 292010 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician 3:25 PM<sup>M</sup> Nancy Eleanor 23, Bell October Auten 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Rehab Burtonsville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F Months 294-12-9923 93 20, 1917 Director April Ohio Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Director 1 ☐ Yes 2 ☐ No MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6759 Great News Lane 21044 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ John William McIntyre Edith Loretta Massie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Harrison - Daughter 6759 Great News Lane Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Important: If it any Injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) Powhatan Cemetery 10/29/10 4 □ Donation Powhatan Point, OH 22. Name and Address of Facility Bauknecht-Altmeyer Funeral Home 441 37th St., Bellaire, OH 43906 21. Signature of Funeral Service License Mun 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician HRONIC BSTRUCTIVE ULMONARE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part 1. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ONOHIECTASIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of eause of death?
1 ☐ Yes 2 ☐ No EMENTA 24a. Was an page 2 s DUSPHACTIA 1∐ Yes , 2□No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 📉 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M 112014 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BACTO SMITH State Registrar

DHMH 17 Rev 1/2001

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

29 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar  Amend Item State of Maryland Department of Health and Mental Hygiene Certificate of Death  Certificate of Death  Reg. No. 0   0   3 3 9 5 8											
	Physicia		1. Decedent's Name (First, Middle, Last)  ARH  ARH  ARTHUK	2			2. Date of Death				
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- September 1			Seasons Hospice  5. Social Security Number   6. Sex   7. Age (In yrs. last bir	thday)	Bal If Under 1 Year	timore If Under 24 Hrs.	8, Date of Birth	N/	9. Birthplace (State or Foreign		
	Funeral Director		4 DM o DY	Yrs.	Months Days	Hours Min.	12/30/	1951	Maryland		
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Maryland	2 should be th and Ment 27 is marke traumatic	۲	Eugene Dale		Magoda.	ene La	weren	<del>CO.</del>			
_	2 sho Ith and 27 is i		19a. Informant's Name/Relationship (Type, Print)  Reginald Arthur(husband)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co								
Baltimore,	ge 1 and 2 s nt of Health : If item 27 or other tra		20a. Method of Disposition 20b. Place of	of Dispos	sition (Name of natory or other place	! .			- City or Town, State		
<u> </u>	. Page 1 ment of tant: If it jury or o			nsv:	ille cer	m. 11/0			sville,MD		
Ball	permit. Page Department of Important: It any injury or once.		21. Signature of Funeral Service Licensee	22.	Name and Addres	s of Facility FuBESNI	ave:, E	unera	ore,MB 21217		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									Approximate Interval Between		
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00 X	r use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal deat	Ectopic pregnanc	у			ate of delivery onth Day Year			
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Division of Vital Records, tal or Attending Physician: The law require:	ing Print ifter th uneral		27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b.		· · · · · · · · · · · · · · · · · · ·						
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	or en rospital of Attending Priysician: within 24 hours affected death. To the Furneral Director After this certific completed filled in by the funeral director, i	Medical	2ga. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	то me within To the сопр	Σ	only one) 3 Li Certifying Nurse Practioner: To the best of my know 29b. Signature and title of certifier	vieuge, u	29c. License				ed (Month, Day, Year)		
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			30. Name and address of person who completed cause of death (Item 23a)	(Type, P	rint)	hon b	11	2/0	25, 2010		
	Stat	e	31. Date filed (Month, Day, Year) 12. Registrar's Sign fare	This can	Ked 1		- 4	<u>~</u> .			
	Registra		OCI & O ZOIO PERON P. A.	MA EAC							

0-07773 serald Andersen	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State of Maryland / Department of Health and Mental Hygiene 2010 3395								
		1- For State Certificate of Death Reg. No.  1. Decedent's Name (First, Middle, Last)  2. Date of Death 3. Time of Death 3. Time of Death							
Physicia Jedical Examir		Gerald Andersen Month Day Year October 9, 2010 1903 hrs							
		4a. Facility Name (if not institution, give street and number)  Suburban Hospital  4b. City, Town, or Location of Death  Bethesda  Montgomery							
Funeral Director		5. Social Security Number 100-24-3401 6. Sex 12 Mark 2 F 67 Yrs. 67 Yrs. 67 Yrs. 67 Yrs. 67 Yrs. 67 Yrs. 67 Yrs. 67 Yrs. 67 Yrs. 67 Yrs. 67 Yrs. 67 Yrs. 67 Yrs. 67 Yrs. 67 Yrs. 67 Yrs. 67 Yrs. 68. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) NY							
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits							
Maryland 28a-f show d at once.	tor	MD Charles Waldorf 1 X Yes 2 No  10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?							
the Mau	Director	1020 Jubilee Way 20602 USA							
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	Funera	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 15. Yes 2 No specify: Specify: White							
nours aft	od be	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Sual Occupation (Give kind of work done during most of working life DO NOT use retired)  16b. Kind of Business/Industry							
D36 thin 72 hae.	Completed	Elementary/Secondary (0-12) 12 College (1-4 or 5+) Security Guard Security							
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	ادہ	17. Father's Name (First, Middle, Last)  Peter N. Andersen  18. Mother's Name (First, Middle, Maiden Surname)  Emma B. Lang							
MD 212 Id 2 should be ulth and Ments m 27 is mark aumatic even	To B	19a. Informant's Name/Relationship (Type, Print) Elaine Dively/ Sister  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Dorchester Dr., Apt 308, Pittsburgh PA 15241							
Baltimore, Normit. Pages I and Department of Health Important: If item		20a. Method of Disposition  1							
Balti permit. Departm Importi injury		2. Funeral S or P. Doda Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230							
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease a. Atherosclerotic cardiovascular disease							
Examiner		or condition resulting in death)  Due to (or as a consequence of):							
	Examiner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated							
ecuted and transit		events resulting in death) Last  Due to (or as a consequence of):  d.							
	edical	X UNPENDED AMENDED, 27, per ME g909 11/5/10 TT							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown							
b, P.O. B ires that the d signed by the	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 V No 3 Probably 4 Unknown							
Division of Vital Records, Ista or Attending Physician: The law requires is after death.  In Director: After this certificate has been signed in by the funeral director, page 2 should be	ompleted	24a. Was an autopsy prior to completion of cause of death?  performed? death?							
Vital Rec ysician: The I his certificate I director, page	CIL	1 ✓ Yes 2 No 1 ✓ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one)							
f Vita Physica er this ce	P	examiner? 1 V Yes 2 No  1 No 28a. Date of Injury  2 ER/Outpatient 3 DOA  Other 4 Nursing Home 5 Residence 6 Other:  28b. Time of Injury 28b. Time of Injury 22c. Injury at Work?  28d. Describe how injury occurred							
ision of Attending Pher death.	ation:	1 Natural 5 Pending 2 Accident Investigation							
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Certification:	3 Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)							
Divi To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
To Your	Me	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)							
end	1	30. Name and address of person who completed cause of death (Item 23a)							
i		Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201							
Sta Regist		31. Date filed (Month, Day, Year)  OCT 29 2010  32. Registrar's Signature							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ row Medical 4c. County of Death Facility Name (if not institution, give street and number) Town, or Location of Death 4b. City, **Examiner** mmon 8. Date of Birth A (Month, Day, ) If Under 1 If Under 24 Hrs. Birthplace (State or Foreign
 Agountry) **Funeral** Min. 1 □ M 2 🕱 F 1 Months Director Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location Examiner must be notified at Director 1 X Yes 2 No more 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 2 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) injury or other traumatic event, the Medical 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) lFriend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2010 2. Name and Address of Facility f Funeral Service Licens Signature 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregr Ectopic pregnancy in the past 12 morths?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 5 Other (specify) g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 hknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Other: 2 3 1 Tes ည 1 🗌 Inpatient 2 🗀 ER/Outpatient 3 🖵 DOA Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Contifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practioner: To the est of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature of certifie 2010 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 21228 MY Registrar's Signature State

Registrar
DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last)
Richard Charles 2. Date of Death Boblitz Physician/ Month 10 19/10 12:30pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 308 Sparta Ct Harford Bel Air 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 219-50-6732 1 🔀 M 2 🗆 F 61 Months Days Hours Min. 6/174/1949 Director MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City. Town or Location Director MC Harford Bel Air 1 Yes 2 XXIII 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 308 Sparta Court Funeral 21014 USA Was Decedent Ever in U.S.

Armed Forces?

Air Force Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married としている , つつ , Maryland 21215-0036 1 Yes 2XXNo Specify: If Yes, Give 67 - 68White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 Insurance Adjuster Insurance Be 17. Father's Name (First, Middle, Last)
Richard H. Bo 18. Mother's Name (First, Middle, Maiden Surname)
Lillian Heim H. Boblitz 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 308 Sparta Ct., Bel Air MD 21014 Dona Boblitz / Wife Baltimore, Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Crownsville Veterans Cem. 10/25/2010, Crownsville MD 4 ☐ Donation 5 ☐ Other (Specify) Victor P. Charles L. Stevens Funeral Home, 1501 East Fort Avenue, Baltimore Doda Inc. MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) signed by the a 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s autopsy performed Yes 2 2 X No 1 L Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 X No ျ 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred / fter 1 Natural 5 Pending injury Accident n 24 hours a er death.

le Funeral Director; A

pleted filled by the tu Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) MD2192

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 33972 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Year Month Edna Louise Brown 26, October | 7:30 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Hospice Center 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Months Days Hours Min. 1 M 2 🔀 F **Director** Yrs 939 <del>214-36-9642</del> Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1214 Bennett Place 21015 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Completed 3 Divorced 4 Divorced Specify. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Agent Life Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Cameron Dudley Simmons Edna Blanche Simmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane A. Couchman / Daughter <u>1605 Copper Gate Ct., Bel Air, MD 21015</u> 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Darlington Cemetery 10-29-10 Darlington, Maryland Signature McComas Funeral Home, P.A. -1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician, Cancel adeno concuma month Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year the hed 9 Unknown 9 Unknow signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Yes certificate has been si irector, page 2 should l Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 XN 2 No 1  $\square$  Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) S I LL 1 🗌 Yes 2 **N**O မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide injury 5 Pending work 1 Yes 2 No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 24 hours after deatle Funeral Director: completed filled in by the within 2 To the I

29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death occu	on, in my opinion, death occurred at the time, date	and place, and due to the cause(s) and manner stated
29b. Signature and title of certifier	29c. License number \$8303	29d. Date signed (Month, Day, Year) OCPOLIC ZO (0)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	. Charles ST TO	nison M

State Registrar

DHMH 17 Rev 7/2009

32. Registr s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ October 24, 2010 A M 9:55 Mario E. Biciocchi Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Bethesda 7501 Democracy Blvd., #293B If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number Age (In yrs. last birthday) **Funeral** (Month, Day av 31 Days 1 X M 2 □ F Months Hours Min. Year) Yrs. 1919 Pennsylvania 162-16-4292 91 May **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location aţ the Maryland Director other traumatic event, the Medical Examiner must be notified 1 ☐ Yes 2 🕅 No Bethesda Maryland| Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral United States items 23a 20817 #293B 7501 Democracy Blvd., permit. Page 1 and 2 should be filed within 72 hours after death <sup>1</sup> Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S.
Armed Forces?

1 ☑ Yes 2 ☐ No 1945—
If Yes, Give 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Divorced 4 Divorced 1946 Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Federal Government Deputy Director of Procurement Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Maria Stephanini John Biciocchi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7501 Democracy Blvd., #293B, Bethesda, Maryland 20817 Mary I. Biciocchi /Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November Arlington National Cemetery X Burial 2 Cremation 3 Removal from State 29, 2010 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22, Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 21. Signature of Funeral ryice Licensee M01305 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Multiple Myeloma disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_ in the past 12 months? Day 2 No the a g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Chronic Renal Insufficiency 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No page 2 2 🗌 No 1 🔲 Yes Be Was case referred to medical 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\boxtimes$  Residence 6  $\square$  Other (Specify) 1 X Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA မ in by the funeral 28a. Date of injury 28b. Time of 28c. Injury at work? 27. Manner of Death 28d. Describe how injury occurred Certificate: (Month, Day, Year) X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 🗌 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homlcide determined

**Division of Vital** after deat Director; hin 24 hours af the Funeral Di npleted filled ir within 2 To the I complex

State Registrar

10215 Fernwood Road, Bethesda, Maryland 20817 Hirshfield, M.D. 31. Date filed (Month, Day, Year) OCT 29 2010 32. Registrar's Signature

ause of death (Item 23a) (Type, Print)

Medical

29a. Certifier

(Check

only one)

David W.

3

30. Name and address of person who completed q

29b. Signature and title of dertifie

🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Centifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

D0057896

City or Town, State)

29d. Date signed (Month, Day, Year)

October 25, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 26,2010 Physician/ Month Ruth E. Barnard October 9:25 Α Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Timonium 5. Social Security Number 8. Date of Birth (Month, Day, Year) Jan, 6, 1918 Funeral 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 □ M 2√□ F Months Days Hours Min. Maryland 217-09-1752 92 **Director** Usual Residence of Decedent ms 23a or 28a-f shov must be notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "natural". or items 93a or 98a.f ehm 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Baltimore 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21234 2907 Cub Hill Road Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married white 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Western Maryland Elementary/Seconday (0-12) College (1-4 or 5+) Chief Clerk Railroad Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Amelia C. Mavers George L. Grund 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6919 A.German Hill Road-Baltimore, Maryland 21222 Rosalie B. Coffman 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Parkwood Cemetery 1 🔀 Burial 2 🗆 Cremation 3 🗋 Removal from State 4 🗋 Donation 5 🗆 Other (Specify) Oct.30,2010 Parkville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 -ordrale LM: Fords 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition GASTROINTESTINAL BLEED Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Litter Underlying Cause (Disease or linjury Due to (or as a consequence of): that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Hospita or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Other: Certificate: To 1 🗌 Yes 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 2 🗌 No Accident Investigation filled in by the Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and itle of of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

OCTOBER

JACKIE JONES,

31. Date filed (Month, Day, QCT 2

CRNP

y 2010

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ october 27, 2010 3:55 A.M Rollo J. Bush, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore 4b. City, Town, or Location of Death **Examiner** Gilchrist Hospice Towson 8. Date of Birth

(Month, Day Year)

January 18, 1931

Balt., Maryland 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Funeral Days Hours 1 **X**M 2 □ F 215-28-3804 79 Director Usual Residence of Decedent show 10b. County be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits aţ Director or 28a-f sl Baltimore Maryland Timonium 1 Yes 2 No 10e, Street and Number 10f. Zip Code ö 10g\_Citizen of What Country? United States must be Funeral 21093 28 Cinder Road America 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married X Yes 21215-0036 1 Yes 2 X No Specify: white If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) State of ntal Hygiene. ed other than " event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Maryland Traffic Engineer Be Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F ည Rollo J. Bush, Sr. Goldie Grim traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. John S. Bush/ son 8 Crotona Court Timonium, Maryland 21093 Department of Health Important; If item 27 any injury or other tr Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Evans Funeral Chapel Belair October 1 Burial XXCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 28, 2010 Forest Hill, Maryland of Fundinal Service Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Inter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Gevelorovascular disease disease or condition resulting in death) mouths Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) Hospital or Attending Physician: The lay requires that the death certificate be executed 24 hours after death.

Funeral Director, After this certificate here. that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Dementia, seizure disorder, coronany artens 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed discase 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? Yes 2 A No 2 🗌 No 1 🗌 Yes Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 □ Nursing Home 5 □ Residence 6 🕽 Other (Specify) H 50. C 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 29b. Signature and title of certifier D0070635 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 4105 Baltimore, 6701 N charles St Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Helen A. Brunnett October 2010 2:45a Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death Randallstown Examiner 4c County of Death Baltimore Seasons Hospice at Northwest Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) April 15 1940 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Days Hours 1 M 2 XF 70 Country) 213-36-9212 Director Vre MD Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location Sykesville 10a. State 10b. County 10d. Inside City Limits by Funeral Director Carrol1 MD 1 Yes 2 No 10f. Zip Code 21784 10e Street and Number 10g. Citizen of What Country? 5780 Oakland Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 📉 No Baltimore, Maryland 21215-0036 Specify: white If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Completed 3 ¥ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) domestic homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Belva Tawney Fred Kapraun 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 230 Warfieldsburg Rd., Westminster, MD 21157 James Burnnett (son) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
All County Cremation 10-29-10 20c. Location - City or Town, State Sykesville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Haight Funeral home % Chapel 21. Signature of Funeral Service Licensee P.O. Box 195 Sykesville, MD 21784 ▶ Yough Haight Herbert 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final End Uronic Obstructure Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** S uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) that initiated events Due to (or as a consequence of) resulting in death) Last nding physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Street at time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Nonknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other (Specify) Other: 2 9 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Matural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 24 hours after death. Funeral Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the F only one) 29b. Signature and title 10043375 121200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smoth Ne 1/ANETV 2835 W.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBE! 2010 10:05M Stanley Francis Bond Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Hagerstown Washington 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 ₺ M 2 □ F Months Davs Hours Min. Feb 11, Year 1921 Mary Tand Director 89 220-03-1894 Usual Residence of Decedent or 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov 10a. State 10b County 10c. City. Town or Location 10d Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No MD Hagerstown Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 USA 20 Redwood Circle 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ruth Rose Mooney Stanley Francis Bond Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Redwood Circle; Hagerstown, MD 21740 Sarah Bond - wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it ò 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State injury o 4 Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board Signature of Funeral Sir 655 W. Baltimore St; Baltimore, MD 21201 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Einal Physician/ disease or condition domina Medical resulting in death) Due to (or as a consequence of) Examiner Securatically list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Vear Pregnant at time of death Unknown Vec 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has be completed filled in by the funeral director, page 2 s performed Ves 2 No autopsy death? Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 No Other: မြ 1 Tes ER/Outpatient 3 DOA 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

1ahmos

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 19ay 2 d 126 8:35 A M Tumake Blackwell Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Future Care - Lochearn If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Days Hours May 14, Year 976 Maryland **Director** 218-98-3946 34 Usual Residence of Decedent 10a. State at 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director must be notified 28a-f 1 X Yes 2 No Baltimore ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must b Funeral USA 21207 5621 Wayne Ave 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. black þ 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 K No Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 disabled none other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked of permit. Page 1 and 2 should be file Department of Health and Mental Finportant: If item 27 is marked o any injuy or other traumatic evenes. Brenda Meekins Lawrence Blackwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1700 W. Edmondson Avenue; Baltimore, MD 21223 Lawrence Blackwell - father Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 22. Name and Address of Facility State Anatomy Board Sign turo Funeral Service Licensee ector 655 W. Baltimore Street; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Emos Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of burial-transit Due to (or as a consequence of): ŵ resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as the b IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Dav Pregnant at time of death 5 Other (specify) Year 9 Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à cate has been sig page 2 should b 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🔀 No ည 4 Mursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 10043375 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VINEN W. WIRNITT 3835 8mith AVE Suite 203 BAZTIMOLE, MD 21209

Registrar

State

KATHEN W. METERITT

292010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20 560M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 20 TOV creter 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) UNK 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 ☑ M 2 ☐ F Months Days Min. Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentai Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examination. 10b. County 10a. State Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 150 E. Main Street 21921 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1X Never Married 2 Married 1 ☐ Yes 2 X No Specify: white Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 teacher education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5 S. Hickory Ave; Bel Air, Maryland 21014 Deborah Skillman - guardian 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other placel 22. Name and Address of Facility State Anatomy Board 21. Sign 655 W. Baltimore Street; Baltimore, MD 21201 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician a I for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by morex io Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed?

Yes 2 No this certificate To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 [X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ieral Director: After the filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Suicide
Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29d. Date signed (Month, Day, Year) Ini cech far MD

Registrar

State

ed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Year **Physician** Judith Kay Bracho 25, 2010 1:38p October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot Genisis Health Care-The Pines 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🕅 F Indiana Director 303-44-3378 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or items 23a or 28a-f shate. Medeal Examinar must be notified Director MD 1 ∏Yes 21 No Talbot Easton the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 21601 301 Sycamore Avenue USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Judith Bracho Baltimore, Maryland 21215-0036 1 Never Married 2 Married 1x Yes 2 □ No 1960-If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 Divorced 1963 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "ranging any linjury or other traumatic event, the "Not once. Elementary/Secondary (0-12) College (1-4or 5+) 0 secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hubert Wayne Unger Marjorie Ruth Adams ဂ္ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leandro Bracho - husband 301 Sycamore Avenue; Easton, Maryland 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signa ure of Funeral Service Licensee ade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street; Baltimore, MD 21201 23a. Part 1. Exter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) remia **Physician** 12.2/25 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner webril metastases law requires that the death certificate be executed 0 and burial-tran Due to (or as a consequence of P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Year Month 5 Other (specify) signed by the a 9 Unknown Part II. Other, significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≦ cate has been signated bage 2 should b Yes 2 No 3 Probably 4 Unknown Completed rabetos mo 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 🗀 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes No Other: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Certification: To funeral c 28a. Date of Injury (Month, Day, Year) 27. Manaer of Death 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending 1 ☐Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident investigation completely filled in by the 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainter as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month

Day, Year

29 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [ = State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Richard B. Brogan Manth 0314 AM 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital N/A Baltimore City Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral XXM 2 □ F Months Davs Hours Month, Day Yea 215-14-4260 88 Director MD Usual Residence of Decedent marked other than "natural", or items 23a or 28a-f shov matic event, the Medical Examiner must be notified at 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Parkville 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Cou Funeral 3106 Woodring Avenue 21234 USA 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Navy Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white If Yes, Give Specify: 44 - 463 Widowed 4 X Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) 2+ Manufacturing Project Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Patrick Brogan ပ Mary Bourke 19a. Informant's Name/Relationship (Type, Print)
Linda J. Snyder / Niece 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $4025\,$  Wilkens Avenue, Baltimore MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State New Cathedral Cemetery 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/30/10 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Victor P. Doda 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc 1501 East Fort Avenue, Baltimore MD D 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) one Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death Year signed by the a Id be detached fi 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has b lirector, page 2 s autopsv death? Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) the funeral 27. Manner of Death 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 24 hours after deat Funeral Director: Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in the opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifie 355/00W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union emorial Day, Year) 2010 32. Registrar's State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Robert Tee Burrell Month 10/27/2010 2:55am<sup>™</sup> Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death
Anne Arundel **Examiner** Baltimore Washington Medical Center Glen Burnie 7. Age (In yrs. last birthday) Social Security Numbe If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 8. Date of Birth **Funeral** 218-16-4365 1**X** M 2 □ F Months Days Hours Min. **Director** Usual Residence of Decedent or 28a-f shov 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d, Inside City Limits other traumatic event, the Medical Examiner must be notified at **Funeral Director** MD Anne Arunde Pasadena 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 8340 Fairwood Drive 21122 USA items 23a 12. Was Decedent Ever in U.S. Armed Forces? Army 1XXYes 2 \( \subseteq \text{No Aii} \) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status rces? Army

2 No AirCorp 1 Yes 222No Specify: 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates white Specify. 3 XXVidowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. I other than ' life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Correction Hearing Officer Correctional Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Humportant! If item 27 is many injury or other 17. Father's Name (First, Middle, Last)
Fitzhugh Lee 18. Mother's Name (First, Middle, Maiden Surname) Edna Olive Shank ပ Burrell 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8340 Fairwood Drive, Pasadena MD 21122 19a. Informant's Name/Relationship (Type, Print) J. Ilene Ferguson / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 11/2/2010 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Euneral Service Licensee VICLOY P. <sup>22</sup> Name and Address of Facility
Charles L. Stevens Funeral Home, Inc.
1501 East Fort Avenue, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Once Ind Death Immediate Cause (Final Lardio Varcular Physician/ Arterio Se disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ilinjury Examine Due to (or as a consequence of): within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Year Pregnant at time of death Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by

29a. Certifier (Check

23e. Did tobacco use contribute to the cause of death?

1 Tyes		3 Probably	4 🗌 Unknov
4a. Was an	24b.	Were autopsy fin	dings available
autopsy		prior to completion	on of cause of

25. Was case referred to medical examiner? 27. Manner of Death

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year)

4 Nursing Home 5 Residence 28b. Time of 28c. Injury at injury

T LI Tes Z LI NO	
Other (Specify)	

1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

work? 1 ☐ Yes 2 ☐ No

Other:

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 No

28d. Describe how injury occurred

Yes

PASADENA, MD 21122

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier mae M

021684

26. Place of Death (Check only one)

29d. Date signed (Month, Day, Year) 10.27.2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8021 C.V. CYRIAC. M.D KITCHIE

31. Date filed (Month, Day,

32. Registrar's Signature

State Registrar

Certificate: To

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 Sherman Lee Cook October 9:00 Р₩ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore <u>Stella Maris</u> Timonium . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) 11/28/1934 1 XM 2 □ F Months Days Hours Min. Country) Virginia Director 225-44-2636 75 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Baltimore White Marsh Maryland 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be any injury or other traumatic event, Funeral 10828 Philadelphia Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ð 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify: Specify 3X Widowed 4 ☐ Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Factory Worker Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Della Samuel Cook Lawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) White Marsh, Maryland Lucille Welch (Sister) 10828 Philadelphia Road 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue Maryland 23a. Part 1. Enter the disease, or complications the scaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ DEMENTIA disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Physician/Medical Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No page 2 should be detached for 5 Other (specify) Month Day Year been signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician: The law requires Records, Completed 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' Hospital or Attending Physician: The 24 hours after death. Funeral Director: After this certificate I sted filled in by the funeral director, page 2 K N Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Certificate: To 1 Yes 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPTCE 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5  $\square$  Pending Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

9:00 р.ш

OCTOBER

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title.

31. Date filed (Month

JACKIE JONES,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

CRNP

2300 DULANEY VALLEY RD.

3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

TIMONIUM. MD 21093

nth. Dav. Year) 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier ? 33984 1 - For State Registrar Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Physician OFIS October 26,2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner 4a. Facility Name (If not institution, give street and number) 6. Sex Homewood If Under 24 Hrs. 8. 0 If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign **Funeral** Months Days Hours Min 1□M 200 F 213-32-3498 Usual Residence of Decedent Director the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or itema 23a or 28a-f shov other traumatic event, the Maxical Examiner in ust be notified at 1 Yes 2 □ No Completed by Funeral Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt 50 225 2 on 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Hace - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) d 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) To Be ornel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health 212 ve 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of F Importent: If Ite any Injury or of once. 1,XBurial 2 □ Cremation 3 □ Removal from State 2010 Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Joseph L. Russ Funeral H. 2222 W. North Ave. Baito. atelle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Stare End renal discore Much /Medical Due to (or as a consequence of): Examiner HYPERTENJION Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ▼ No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the a 9□ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 3 Probably 4 Unknown Completed 1 Tyes 2 No (crebroyasw)ar 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 2 No 1 ☐ Yes 2 No 1 ☐ Yes or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Medical Certification; To 1 🗌 Yes 2000 4 Voursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registrar Dalled Saluja 31. Date filed (Month, Day, Year)

Salvic

29b. Signature and title of certifier

yoth St 702 Most 2. Registrar's Signature

Dalicet Saluse MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D0059056

Bell MO

29d Date signed (Month, Day, Year)

10/26/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October Physician/ 2010 Sherman Lowe11 Cohen 9:40 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death APEX Nursing Home Silver Spring Montgomery Social Security Number 8. Date of Birth (Month, Day, Year) April 10, If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Country) ew York 1 X M 2 D F Hours Director 79 133-20-9402 1931 New Usual Residence of Decedent or 28a-f show notified at 10a. State within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Montgomery Silver Spring 1 Yes 2 X No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 9617 Bristol Ave. 20901 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ⚠ Yes 2 ☐ No If Yes, Give 1 0 5 1 — 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2XXMarried Maryland 21215-0036 1 ☐ Yes 2X No Specify: White "natural" Completed 3 Widowed 4 Divorced Year or Dates. 1951-57 the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ge 1 and 2 should be filed within 72 it of Health and Mental Hygiene.

If item 27 is marked other than "r or other traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Technical Writer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ David Cohen Molly Wisbaum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gwendolyn Ann Cohen (Wife) 9617 Bristol Ave., Silver Spring, MD permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other 3 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) Uniformed Services Oct.26,2010 Bethesda, MD 22. Name and Address of Facility
Rapp Funeral and Cremation Services
933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) nRveum Medical Due to (or as a consequence Examiner Sequentially list conditions Examiner if any, leading to immediate cause Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transii that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year cate has been signed by the page 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? truction rulmanary 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has be performed Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 2 Accident 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28a. Date of injury Certificate; 28d. Describe how injury occurred (Month, Day, Year) 5 Pending injury Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

State
Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

043121

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #12 Per FH 6909 11/03/10 The State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	•	ificate of L		vioritai i iy	Reg. N	2010	33986			
Physician			1. Decedent's Name (First, Middle, Last)				2. Date of De Month		ay Year	3. Time of Death			
Medic Examin		al	Ryan Cascarelle  4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death			occober 20, 2010					
	CAGIIII	er	Gilchrist Center for Hospice C		Towson			4c. County of Death  Baltimore					
A) i	Funeral Director		5. Social Security Number 6. Sex 1 M № 2 ☐ F 7. Age (In yrs. last 1 M 2 ☐ F 33		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Mar 0	th Yea <i>r)</i> <b>2</b>	1977 S. Bii	thplace (State or Foreign wintry) iichigan			
	at at	or	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City										
	Maryla 28a-f s stified	Director	MD Howard Co	lumbia	ia				1 🄀 Yes 2 □ No				
	h the la or 2	al Di	10e. Street and Number		10f. Zip Code			10g. C	itizen of What C				
	ath will	Funeral	6358 Wind Rider Way  11. Marital Status  12. Was Decedent Ever in U.S.	13 Ws	2104	.5 ispanic Orlgin? (Sp	ecify Yes or No-		United  14. Race - Ame				
036	should be filed within 72 hours after death with the Maryland nand Mental Hygiene.  7 is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	by	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1997— 1 No 2003 If Yes, Give Year or Dates.	If Y	Yes 2 No	ın, Mexican, Puerto	Rican, etc.)		Black, Whit				
2-0	2 hour "natu	plete		16a. Deceder	nt's Usual Occupa	ation during most of work	ina		Kind of Business	,			
12	thin 7; ene. than he Me	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)	life. DO l	NOT use retired)	e Analys			Departm Defense				
<b>5</b>	iled wi Hygie other ent, t	æ	17. Father's Name (First, Middle, Last)	11106	elligend	18. Mother's Nam							
ylan	d be fi Menta arked atic ev	욘	James Alan Cascarelle			Ann L	ouise R	idle	∍у				
, Mar	id 2 shoul salth and I n 27 is m er trauma		19a. Informant's Name/Relationship (Type, Print)  Ann Louise Cascarelle /Mother	-		and Number or Rur Dodge Roa				p Code)			
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic evence.		1 Burial 2 Cremation 3 Removal from State ceme	etery, cremat	tion (Name of tory or other place Cremato		Date Oct 29 2010		ocation - City or Beltsvil	Town, State			
Balt	permit. Departr Import any inji	8 20	21. Signature of Funeral Service Licensee MO158	5 22. N		ss of Facility on and Fun een Pastur				rland 21286			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  8717 Green Pastures Drive Towson Maryland 21286  Approximate Interval Between										
4	hysician/ Medical	ð þ	Immediate Cause (Final disease or condition  Angulate Cause (Shocy from 4 1 Cause)										
	Examiner		resulting in death)  Due to (or as a consequence)	ce of):									
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3/60	tificate be executed ng physician and as the burial-transif	Medical	d										
9	death certif he attending ed for use a	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat	eath 3 🔲 E	Ectopic pregnanc Other (s <i>p</i> ec <i>ify</i> )	y		I	23d. Date of de Month	livery Day Year			
o o	that the c	Phys	g Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting	ng in the und	lorlying course giv	ron in Bort I				11 ( )			
ds, P.	requires that the death cert been signed by the attendir should be detached for use	ted by	Part II. Other significant conditions contributing to death but not resolute	ig in the and	errying cause giv	en in Fait i.			2-4	the cause of death?			
Division of Vital Records,	To the Hospital or Attending Physician: The law requires within 24 hours after death.  To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be	Completed					24a. Was autor perfo		prior to death?	topsy findings available completion of cause of			
ta	cian: certific ector,	Be	25. Was case referred to medical examiner? Hospital:		26. Pla	ace of Death (Chec	k only one)						
<u> </u>	Physic r this c ral dir	은 ::	1 Inpatient 2 ER/ 27. Manner of Death 28a. Date of injury 28t	Outpatient b. Time of	3 DOA 28c. Injury	4 L Nursing H	ome 5 Resident		Other (Spec	in hapice			
u C	nding ath. r: Afte e fune	icate	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	injury	work'		20d. Describe n	ow Inju	ry occurred				
DIVISIO	tal or Atters after destal Directored in by the	Il Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
-	he Hospit in 24 hour he Funera pleted fill	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledg Medical Examiner: On the basis of examination and Certifying Nurse Practioner: To the best of my knowledg	nd/or investiga	ation, in my opinio	n, death occurred a	t the time, date a	nd place	e, and due to the	cause(s) and manner stated.			
	Voit To t		29b. Signature and title of certifier		29c. License	ククシコ			ate signed (Monti				
			30. Name and address of person who completed cause of death (Item 23:	a) (Tuno Dii	1 0 30			00	osen a	27 2010			
1			30. Name and address of person who completed cause of death (item 23:	a) (Type, Prin	N.Ch	varies s	ST JOY	12x	w w	0			
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10-08109 Mark Copeland Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 22987

nark Coperand		1- For State Registrar	ate or Maryland		rtificate of l		iu ivieritai	10	ZUI	0 3398
Physici		Decedent's Name (First, Middle						2. Date of Dea	ath	3. Time of Death
Medical Exami	mer	Mark E. Copela  4a. Facility Name (if not institution			I 4h	City Town o	or Location of De	Month October 2	23, 2010 4c. County of De	1257 hrs
		Calvert Memorial Hosp				Prince Fre		aui	Calvert	aut
Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. I	ast birthday)	If Under 1 Ye			rth(MM/DD/YYYY) 9. I	Birthplace (State or eign
Director		263-93-6154	1XM 2F	45	Yrs.	Months Da	ys Hours N	Jan.	16, 1965	Country) Florida
any		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Location	1				10d. Inside City Limits
yland I-f show	ō	Florida Mana	tee	Pa	1metto					1 Yes 2 X No
h the Maryland 3a or 28a-f sho otified at once,	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of What Co	ountry?
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hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	Funeral	1 Never Married 2 Ma	rried Armed Forces				n, Mexican, Pue		White, etc.	
after o	by F		orced If Yes, Give Year			es 2X N			Specify: W	
336 thin 72 hours a re. than "nature edical Exami	ted	<ol> <li>Decedent's Education (Specific Elementary/Secondary (0-12)</li> </ol>	College (1-4 or		16a. Decedent's during mos		ation (Give kind o e. DO NOT use r		16b. Kind of Busines	s/Industry
5-0036 led within 72 Hygiene, other than "	Completed	11	Jonege (1 4 of	.,	Contr	actor			Construc	tion
		17. Father's Name (First, Middle,	•		1		18.Mother's Na	me (First, Middle, I		
21215-0036 wild be filed within 7 Mental Hygiene, marked other than c event, the Medica	To Be	Robert Wayne Co			19h Mailing A	ddress (Stre		n Kinsey	mber, City or Town, Sta	ate Zin Code)
e, MD 21 I and 2 should Health and Mel item 27 is man	1	Robert Wayne Co		her)					lenton, FL	
imore, MD 2 Pages 1 and 2 shou ment of Health and N lant: If item 27 is n or other traumatic		20a. Method of Disposition  1 Burial 2 X Cremation	3 Pemoval from St		Place of Disposition	on (Name of ce		Date	20c. Location - City	
Baltimore, permir. Pages 1 at Department of He Important: If ite		4 Donalion 5 Other Sp	ecify.		tropolit	an Cre	natory 1	0/27/10	Alexandr	ia, VA
Baltimore permit. Pages 1 Department of I Important: If injury or other		21. Signature of Funeral Service I	811		22. Nar CO	ne and Addres	ss of Facility Ineral H	ome	enton, FL	24205
Physician		23a. Part I. Enter the disease, or o		the death.	. Do not enter the	mode of dying	, such as cardia	or respiratory arm	est, shock, or heart	Approximate Interval
/Medical Examiner		failure. List only one cause of Immediate Cause (Final disease	a. Drowning							Between Onset and Death
		or condition resulting in death)	Due to (or as a conse	equence of	f):					
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	equence of	f):					
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1876 tificate ing phy as the	W/W	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	ne of pregr		death 3	Ectopic preg	nancy	23d. Date of delive Month	ery Day Year
Box 687 death certific the attending p of for use as th	23b. Was decedent pregnant in the past 12 months?  1 Live birth 4 Pregnant at time of death 5 Other (Specify) 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  2 Fetal death 3 Ectopic pregnancy Month 4 Other (Specify) 9 Unknown 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.									
~ ± × 5 5	Ph	Part II. Other significant condition		but not re	esulting in the und	lerlying cause	given in Part I.	23e, Did to	obacco use contribute t	o the cause of death?
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Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be	Com							perfor 1 ✔ Yes	rmed? death? 2 No 1 ✓	
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On central parts on the fun	tion	1 Natural 5 Pendii 2 Accident Invest	ng FOUND: Day,Y Oct 23, 2010	ear)	FOUND: 1125 hrs	1	Yes 2 No	Diver pinned concrete	d under water by	fragment of
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Div ospital or hours afte uneral Dir	ပ	4 Homicide determined	(openin) Day						tate) pint Road, Lusby, Mi	
Division  To the Hospital or Attent within 24 hours after death  To the Funeral Director: completely filled in by the	Medical	(Check only	ysiclan: To the best of my niner:On the basis of exar	_						
To with	Me	29b. Signature and title of certifier	and manner stated.		_	29c. Licen	se number		29d. Date signed (M	lonth, Day, Year)
		D_1401_	may been			O.C.	M.E.		October 24, 20	10
9	30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201									
	ate	31 Date filed (Month, Day Year)	32 Registrar	's Signatu	re#		,			
Regist	rar	UGI 297	2010 Cener	N/	1. pay	1				

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State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #16abb Per ANA BD/6908 10/29/10 HH and Mental Hygiene AMEND ITEM#5,10c,f,16b,20a-c,22perFH,G90911/3/2010,WS2 0 1 0 Per ANA BD 6908 the 10/39/10 all and Mental Hygiene e of Maryland bepartment of 10 all and Mental Hygiene ND ITEM#5,10c,f,16b,20a-c,22perFH,G90911/3/2010,WS/Certificate of Death Reg. No. State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Harold Cunningham 5:03 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George aurel Regional Hospita Laure 5. Social Security Numberunk 6. Sex 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 X M 2 D F Months Hours Min. Aug Pay, Year 48 Director 62 Alabama 578-66-4404 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits MD Prince Georges Hyattoville Laurel 1 ☐ Yes 2 No 10f. Zip Code 20783 20723 10g. Citizen of What Country? 10e. Street and Number 9364 Canterbury Riding Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 black 1 ☐ Yes 2 K No Specify: "natural", Completed 3 🗆 Widowed 4 🙀 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry -Unk-(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Private Welder Elementary/Seconday (0-12) College (1-4 or 5+) David Cunnin Georgia Dial 12th Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David Cunningham George Dial 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Cunningham - sister 8613 Laverne Dr; Adelphi, Maryland 20783 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in State coln Cemetery 11/2/2010 Brentwood, Maryland

22. Na Address of acili 12 Angelowy Roard J. B. Jenkins Fund 1

House W. Baltimore Rd. Hya syille, MD 7/201 Ft. Lincoln Cemetery 11/2/2010 21. Signa (v > of Funeral S ryice sicen ) Mector 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Septic Immediate ause (Final Onset and Death Shock Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ancreatitis To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Physician/Medical Respiratory Failure Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes Mellitus 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed Acute Renal Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Stroke performe 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 XNo Other: ျ 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 124 hours after death.

1e Funeral Director: Af onleted filled in by the fu 2 🗌 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) D69430 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) October 21, 2010 7300 Van Dusen Road aurel Regional Hospital 32. Registrar's Si State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Lillian R. Castranova 12:10pm 10/12/2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Somerford Assisted Living Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** Social Security Number 142–03–8579 Vear Months Min. Days Hours 1 □ M 2 🕱 F Director 7/13/19 NJUsual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the "nacical Exercitors in use to in tillical in Mercer NJ 1 XYes 2 ☐ No Director Lawrenceville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 18 Paddock Drive 08690 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 25 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2000No Specify Specify: by 3 XXVidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygien Important: If Item 27 Is marked other than any Injury or other trainmets. Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Abramo Angelina Leopardi Rossi ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela Wetzel / Daughter 1850 West Queens Ct Crofton MD 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3XX Removal from State Hamilton, St Mary's Cemetery 10/18/2010 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility DATIES L. Stevens Funeral Home, Inc 001 East Fort Avenue, Baltimore MD 21. Signature of Funeral Service LicenseeVictor P. Doda 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** advanced ears disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): burial-1 P.O. Box 68760 physician Physician/Medical the as attending | IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mov 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) the 9 Unknown 9 Unknown þ signed | Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed peen 051 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy certificate 2 □ No 1 □Yes 25. Was case referred to medical examiner? ASSISTED director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ER/Outpatient 3 DOA 6 Other (Specify) 1 ☐ inpatient Certification: To this After thi funeral of of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending ithin 24 hours after death.

the Funeral Director: A
propletely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one within 2 29c. License number 0 50 7 25 29d. Date signed (Month, Day, Year) Sign ure and title of certifier leterans Huy Millesvillemin 21108

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER 24, 2010 11:50 A M LESLIE MARSHALL DANIEL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HARFORD HART HERITAGE ASSISTED LIVING STREET 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🔀 M 2 🗆 F 94 Months Hours Apr. 9 <sup>Year</sup> 91<u>6</u> 403-20-9094 Kentucky Director Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland ᇴ 10d. Inside City Limits Director iral", or items 23a or 28a-f s Examiner must be notified Kentucky Boyd Ashland 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3814 Cactus Street 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White "natural" Completed 3 Nidowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature any injury or other traumatic event, the Medical once." Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Advertising Manager Newspaper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Arby J. Daniel Etta Mae Daniel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marsha Daniel Muir / Daughter 1811 Prindle Drive, Bel Air, Maryland, 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)
21. Signature of Furieral Service Coensee Golden Oaks Mem. Gdn 10/29/2010 Ashland, Kentucky McComas Funeral Home, P.A. Im 317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or com tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only on Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition resulting in death) 1011 Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ģ Pregnant at time of death 5 Other (specify) Month Day Year be detached the 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Hiknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 performed 2 🗌 No Yes 2 No 1 🗌 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence (XX)Other (Specify) Hospital: 2 **N**o မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Assisted this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at s after death. Il Director: After t 28d. Describe how injury occurred Living 1: Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 | Medical Examiner: On the basis of examination and/or investigation, in the opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of certifier MI 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PANUS 611

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33992 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 4:41 owel PM UKIE chuse 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town or Location of Death 4c. County of Death **Examiner** Bellimore Maryland Medical niversitu Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 2007 1 🏻 M 2 🗆 F Months Days Hours Min. (Month, Day Ct. 31 Maryland Director 219-79-6804 Usual Residence of Decedent 28a-f show 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2X No Maryland Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17 Valleylake Place Apt. A 21030 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Divorced Completed White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Never Worked 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Michael David Dowell Tracie Ann D'Antoni traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracie D'Antoni / Mother Valleylake Place Apt. A, Cockeysville, MD 21030 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donatjon 5 ☐ Other (Specify) cemetery, crematory or other place) Hilltop Service Corp. 10/28/2010 Towson, Maryland 21. Signatur of Funeral Service Licensee <sup>22</sup> Name and Address of Facility Home, P.A. McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Respiration disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner seudomono Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 Z No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy death? 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Natural injury Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a Certifier 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 2010

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State

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and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Thomas S. Dominick 1000 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Messen ARYNde center BURNIZ Glen Anno 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 178-32-6396 1**x**xM 2 □ F 67 (Month Day Year) 1/28/43 Country) Director Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items 23a or 28a-f show urv or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arunde Glen Burnie 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 102 South Bend Road 21060 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 1 ☐ Yes 2 No Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XXO Specify: Specify: white 3 Divorced 4 Divorced Doning Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Aero Space Industry Electrical Engineer Be 18. Mother's Name (First, Middle, Maiden Surname)

Josephine Smolak 17. Father's Name (First, Middle, Last) Steve ൧ Dominick 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 856 Freeport Road, Freeport PA 16229 Timothy Dominick 20b. Place of Disposition (Name of cemetery, crematory or other place)
St Mary's Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3X Removal from State 10/23/10 Lower Burell, PA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Victor P. Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Ave., Baltimore MD 21230 Doda 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Small CANCER disease or condition resulting in death) Medical Due to (or a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Uncertying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Pregnant at time of death 1 Yes 2 No ed by the a 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy perform certificate 1 Yes 2 🗆 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 KNo 1 → Inpatient 2 □ ER/Outpatient 3 □ DOA မှ After this 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Director: 6 Could not be Suicide Location (Street and Number or Rural Route Number, City or Town, State) . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours a edical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Jul My 1027 October 16,2010 Name and address of person who completed cause of death (Item 23a) (Type, Print) Cuashington Medical M10 BARtimore FRANC.

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signatury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 29, **Physician** October 2010 4:50 AM Robert Herman English /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carroll Lorien Nursing Home Taneytown If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days XIX M 2 TF 86 216-14-8909 May 6, 1924 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes AXNo Director Maryland Carroll Taneytown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21787 3244 Bert Koontz Road America 12. Was Decedent Ever in U.S.
Armed Forces?

XXYes 2□No 1942−
If Yes, Give
Year or Dates: 1945 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 □ Yes 💹 No Specify: Specify: þ White XXWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Carpenter Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Elmer English Bertha Grove 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3244 Bert Koontz Road, Taneytown, Maryland 21787 Wayne L. English (Son) 20b. Place of Disposition (Name of cameter, crematory of other place)
AII Faiths Crematory
& Chapel Date 20c. Location - City or Town, State 20a. Method of Disposition Oct. 29 1 ☐ Burial 2XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Manchester, Maryland 21. Signature of Fundal Survice License 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 3296 Charmil Drive, Manchester, Maryland 21102 Enter the disease, or complecations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) rveek Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) a I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient Certification: To 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

Physician /Medical **Examiner** and

**Funeral** 

Director

r 28a-f show notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be reany injury or other traumatic event, the Medical Examiner must be reany injury or other traumatic event, the Medical Examiner must be reany injury or other traumatic event.

Baltimore, Maryland 21215-0036

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Division or Vital Records,

funeral o e Hospital or Attending PI 24 hours after death. e Funeral Director: After ti letely filled in by the funeral After To the Hospital of within 24 hours at To the Funeral D

30. Name and address of person who completed ca State Registrar

Medical

2 ☐ Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H0061206 10

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32. Registrar's Signature

use of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Vicki Adrienne Eldridge October 2010 8:00PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital 01ney Montgomery 8. Date of Birth (Month, Day, Ye August 29 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 9. Birthplace (State or Foreign 1 □ M 2 🏻 F Days Min. Months Hours Country) Director 182-38-8708 55 Pennsylvania Usual Residence of Decedent Show be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Completed by Funeral Director · 28a-f 1 X Yes 2 □ No Maryland Montgomery Rockville 10e. Street and Number 10f Zin Code 9 10g. Citizen of What Country? items 23a 1708 Tweed Street 20851 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. ō 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 'natural", 3 X Widowed 4 □ Divorced Specify. White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Administrator Credit traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental Frant: If item 27 is marked o ဂ္ Dorothy Vanvranken Bernard Nurry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 325 Broadwood Drive, Rockville, Maryland 20851 Eva J. Lascelle/ Friend other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of
Important: If it
any injury or o
once. Cemetery, crematory or other place)
Montgomery
Crematorium, Inc 1 Burial 2 K Cremation 3 Removal from State October 3, 2010 O Bethesda, Maryland A. Pumphrey Funeral Home/ West Montgomery Avenue 20850-2805 4 Donation 5 Other (Specify) 28 Inc. 22 Name and Address of Facility Robert Rockville, Inc. 00 Rockville, Maryland 21. Signature of Funeral Service Licensee M00335 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease Approximate Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ 09620 ralo disease or condition Medical resulting in death) Due to lor as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a onsequence of attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last by Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔯 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1  $\square$  Yes 2 No 3  $\square$  Probably 4  $\square$  Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No death? ☐ Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 ី No 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number MAN

State Registrar

DHMH 17 Rev 7/2009

18101 Prince Philip Drive

Olney, Maryland 20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

29 2010

Kona

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Alma Egan  $0^{Month}_{c}$  ober  $^{Day}$  26,  $2^{W}$   $^{O}$   $^{O}$ 7:25 P<sub>M</sub> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3214 Woodside Avenue Parkville Baltimore Social Security Numbe Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral**  Birthplace (State or Foreign Country) (Month, Day, Year) une 14,1921 1 M 2 X F Months Days Hours 214-18-9355 **Director** 89 June\_ Baltimore. Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD Parkville 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? should be filed within 72 hours after death with i and Mental Hygiene. is marked other than "natural", or items 23a Funeral 21234 3214 Woodside Avenue U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) At Home Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Beecher Mamie Frederick permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Egan/ Daughter 3214 Woodside Avenue, Parkville, MD 21234 20b. Place of Disposition (Name of Dillaney, crematory or other place)
Memorial Garcens 20a. Method of Disposition 20c. Location - City or Town, State October 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Timonium, Maryland ☐ Donation 5 ☐ Other (Specify) 29, 2010 21. Si matu 2 Name and Address of Facility Evans Funeral Chapel & Cremation Services 8800 Harford Road Parkville, MD 21234 of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset anghDeath Physician di ese or condition resulting in death) days Medical Due to (or **Examiner** day Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pre 23d. Date of delivery in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Dav Year been signed by the should be detached 9 Unknown Part II. Other significant conditio Alting In the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has blirector, page 2 s autopsy perform death? 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🗶 No Other: ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) After this . Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending
Investigation
6 Could not be 2 🗌 No Accident within 24 hours after deat

To the Funeral Director:
completed filled in by the Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide dex ermined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 3 30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Mc

T 2 9 2010

Registrar's Signature

50

10WSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20a-c, perFH, G909, I1/12/2010, WS

State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Am Es 2:35A M O Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death 4b. City, Town, or Location of Death MIAR BATIMORD *ttos* OICO ONIUM 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign 1 M 2 Months Days Hours Min. NO ZIH 0 Director Yrs. 0 Usual Residence of Decedent Show 10a. State 10b. County the Maryland at 10c. City. Town or Location Director 10d. Inside City Limits r 28a-f sh notified a 1 Fes 2 No MD BALTO ESUI U 10e, Street and Numbe 5 10f. Zip Code must be r 10g. Citizen of What Country? Funeral within 72 hours after death with OLLINSDACE 21226 USA items a 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Examiner Armed Forces Black, White, etc. ö þ 1 Never Married 2 Married 2 3 21215-0036 1 Ves If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: "natural", 3 ₩idowed 4 Divorced Specify: Completed BLACK the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) Bus and Mental Hygien is marked other the DRIVER ITH WIDE 0injury or other traumatic event, Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Himportant: If item 27 is mm.
any injury or other. Baltimore, Maryland filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ti EUDS ENORA 26 Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zo Code) 21205 PATRICI ST DAUGHTEL 2820 BALTU mb 20a. Method of Dispos 20b. Place of Disposition (Name of - City or Town, State 20c. Location - City or T alstonburg, CTOBER 4-2010 1 Jurial 2 3 Removal from State cember 1 12 Htts Cemiace) Cremat St 4 Donation 5 Other (Specify) . Signature of E Service/License 22. Name and Address of Facility FUNGRAL Huurs HOME BALTO MD. DE 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death BREAST CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of; cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death Month Day Year 2 🗌 No signed by the ector, page 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FIELDS, 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? performed? certificate l 2 🗌 No 1 🗌 Yes 2 😿 No 1 Tes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 X No Other: ျှ 1 Yes After this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 To Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) injury **X** Natural 5 Pending Accident 1 Yes 2 🗆 No Investigation within 24 hours after death

To the Funeral Director: /
completed filled in by the f 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, only one) 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES 2300 DULANEY VALLEY RD. CRNP TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ october 27°, 2018° 3:50 Ам Barbara Jane Goodman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Ivy Hall Geriatric Center Middle River If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Social Security Number 6, Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F August 3, <sup>(ear)</sup>1920 Onio" Director |578–46–1130 90 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director ms 23a or 28a-f s must be notified Middle River Maryland Baltimore 1 🗌 Yes 2 🏻 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21220 U.S.A. 1000 Wilson Point Road, Apt. F ıral", or items ? I Examiner mus 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? 1943 1944 Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes : 2 🗌 No Maryland 21215-0036 White 1 Yes 2 No Specify: Specify: "natural" 3 - Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Seconday (0-12) 12 College (1-4 or 5+) Sales Associate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Catherine Schrock Chauncy Lang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21220 1000 Wilson Point Road, Apt. F, Balto., Maryland Carol Schaumberg (Daughter) Baltimore, : If item or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date XXBurial 2 Cremation 3 Removal from State Important: If any injury or Veterans' Cem. 4 Donation 5 Other (Specify) 11/08/2010 Garrison Forest, Md. Signature of Funer Service Licensee <sup>22. Name and Address of Facility</sup>
Bruzdzinski Funeral Home, P.A 1407 Old Eastern Avenue, Essex, Maryland Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final CARDIOVASCULAR DISEAS Thysician, ease or condition Iting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 55101 Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an After this certificate has prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy сотрете filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann f Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 V Natural injury work? 1 🗌 Yes 5 Pending death. 2 🗌 No Accident Investigation after death 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical 29a, Certifier 1 📝 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) andcel State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8 Per ANA BD G908 10/29/10 JH. State of Maryland / Department of Health and Mental Hygiene amend #9,11,15,16b&19a&b Per ANA BD G909 11/01/10 JH/ Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** October 2010 P M Allen A. Gault 7:12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medican Center Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Days) June 30 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 F Pennsylvania 339-24-9470 86 Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show MD Harford Jessup Director 1 ☐ Yes 2 No 10f. Zip Code 20794 10g. Citizen of What Country? 10e. Street and Number 2012 Citrus Ave Funeral 11. Marital Status unk 12. Was Decedent Ever in U.S Armed Forces? Unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 □ Yes 2 1 o If Yes, Give Year or Dates: 1 XX ever Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 🗷 No à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation Uni (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NASA is marked other 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk Be Health and Mental Pages 1 and 2 should 2 19 norman's Namy Brady Friend Ballington Washington M 19b 1070 Woo Gillour Dre or Melauvitte, Fennsylvania 16335 permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau once. Hospital Dr; Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in State 21. Signature of Funeral Service Licensee KOTTA Ld S Wade, 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore Street; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or user failure. List only one cause in each line.

Immediate Cause (Final disease or condition resulting in death)

a. Approximate Interval Between Onset and Death **Physician** sease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed sician and burlal-trans Due to (or as a consequence of): Box 68760 Physician/Medical the attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Vear 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No signed by the a P.O. 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 2 No 1 🗌 Yes 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 □Yes 2 □ No 1 ☐ Yes 2 🗆 No Division of Vital director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 N PR/Outpatient 3 □ DOA Certification: To this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely and manner stated within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier address of person who completed ause of death (Item 23a) (Type, Print) 303

State Registrar Year) 9 2010

37. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ P<sub>M</sub> Ochober 2ª2 2010 ar 4:06 Jervine Gatison Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death
Baltimore Towson Gilchrist Hospice Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Yo Aug II, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Months Days Hours Min. 1943 Mary I and Director 218-44-1134 67 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Nottingham 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 78 Insley Way 21236 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 Specify: black 1 ☐ Yes 2 🖾 No Specify: Page 1 and 2 should be filed within 72 hours aft nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", If Yes, Give Year or Dates Completed the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) laundry aide other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Abie Pearson Evlyn Mack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1919 Patriot St; York, PA 17404 Jeanette Russell - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 X Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Foard 655 W. Baltimore Street; Baltimore, MD 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final thysician/ disease or condition resulting in death) DAR Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, had in a to immediate cause. Enter Underlying Examiner Due to for as a consequence of Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) ttending physician Physician/Medical Box 68760 as or use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day signed by the g 🗌 Unknown Division of Vital Records, P.O. should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by DIABETES MOLLITU 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown peen PERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy PIDOMIA this certificate 1 Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Spe 2 - No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 Natural 5  $\square$  Pending Accident Investigation 1 🗌 Yes 2 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier

State Registrar 30. Name a

31. Date filed (Month, Day, Year)
OCT 29 2010

NORTH CHARLES STREET

nd address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Si